Children in the Shadow of AIDS: Studies of Vulnerable Children and Orphans in Three Provinces in South Africa

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Abstract

This paper examines the experiences of children affected by HIV/AIDS in three provinces of South Africa: Eastern Cape, Western Cape, and KwaZulu-Natal.. By combining the findings of two different studies, the paper analyzes the conditions of children at different stages of impact. It looks at the conditions of vulnerable children living in households with HIV positive members; children at risk of becoming orphans (i.e. children living with HIV positive primary caregivers); and children orphaned after their biological parents have passed away. Using primarily in-depth interviews and observations, the paper contributes toward filling two knowledge gaps—one on children vulnerable to becoming orphans and another on those already orphaned.

In Western and Eastern Cape, we interviewed nineteen HIV positive mothers and primary care givers to investigate strategies employed by families in response to HIV/AIDS stresses, focusing on children and examining how parents plan for the future security of their children. Our results emphasize the role of already established patterns of childcare arrangements as primary safety nets in the context of AIDS in South Africa. Children are intimately involved with providing care, support and assistance in treatment to HIV mothers and younger siblings. Our evidence demonstrates the positive impacts of disclosure of HIV status to children and the ability of children to get involved in the care giving and support of their mothers. We conclude that if we are to ensure the future well-being of children, we must first recognize the roles and responsibilities that children are already shouldering and then empower them through a variety of appropriate polices and programs before they enter orphanhood.

For mothers who are aware of their HIV positive status, making plans for their children represented a chance to take part in the future growth and development of their children. HIV positive mothers are actively planning for the future of their children, within their limited resources. The plans ranged from organizing future care giving arrangements to preparing wills for inheritance. While many of the women in our study emphasized the desire to save for things like the future educational requirements of their children, meager earnings made this rarely possible. In order to strengthen the roles of mothers, we must understand the dynamics of planning, the challenges HIV positive women face in parenting and the strategies they are utilizing in order to secure their children's future This paper calls for inclusion of parents in the future policy and planning surrounding the issue of OVCs in South Africa

In KwaZulu-Natal, ethnographic research methods were used in 6 localities, with repeated visits, interviewing and observation of 18 households fostering orphans, as well as key informant interviews with individuals involved with community-level interventions to support orphans. The paper also draws on a survey dataset of 1,428 households across KwaZulu-Natal.

The qualitative research found that processes of fostering children orphaned by AIDS have articulated with historical patterns of mobility, and with notions of African culture and obligations related to lineage patterns. Family structures are thus far largely coping with the care of orphans, though under the strain of poverty. We found divergence from idealized protocols of patrilineal responsibility because terminally ill mothers are often cared for by their families and children remain in the same household after their mother's death; and because many children do not maintain links with their fathers and/or fathers' relatives. Few conflicts were found around

decisions to take in children, although where they occurred they were related to tensions between the patrilocal residence ideal and the matrilocal status quo; or to efforts to obtain the deceased's property or access to social grants. The main fostering parents are relatives, primarily grandparents and aunts and uncles. People express a strong ideal of African cultural norms that require that orphans be treated the same as the children of the fostering relatives, and observations largely confirmed this—though we also found cases of discrimination against orphans in some households. Survey data on 333 fostered children also show few differences between orphans and non-orphans in schooling-related indicators, which may be because children are fostered by mainly by close relatives. Key informant interviews suggest that child-headed households face particular problems and risks with respect to food and nutrition, schooling, health, violence, crime, discipline, teen pregnancy, and HIV/AIDS. There is a lack of specialized services to assist them.

State grants provide a crucial social safety net for orphans, particularly the Old Age Pension and the Child Support Grant. The survey data show that about 30 percent of fostering households are receiving the Child Support Grant. However, fostering households have a higher likelihood of unsuccessful applications because the applicant was not able to be established as the primary care giver. Only a miniscule percentage of fostering households in the survey are receiving the FCG. The qualitative research found the main reasons for low uptake to be lack of knowledge and assistance with respect to the application process; concern over length of time involved, doubts about success of applications based on observations of widespread failure across one's social networks; and anticipation or experiences of bureaucratic problems.

Apart from grants, most forms of support for orphans were informal. Neighbors and friends help out, but these social networks are made up of poor people with little to share. Material forms of assistance include mainly cash or food donations, loans, clothing, school uniforms and school fees. Creative community-based initiatives included drop-in and community centers offering recreational activities, school performance monitoring, after-school feeding and take-home food, counseling, parenting skills, and assistance with grant applications. These interventions were few and ad-hoc, however, and mainly supported by local contributions, though some had government support. Given the size and rapid acceleration of the orphans crisis in South Africa as elsewhere on the continent, there is an urgent need for a systematic approach to the needs of orphans and fostering households. However, it is also important to find intervention designs that both target orphans and support other vulnerable children, so that policy is non-stigmatizing and fair to other poor children and households.

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Children in the Shadow of AIDS: Studies of Vulnerable Children and Orphans in Three Provinces in South Africa

1. Introduction

This paper examines the experiences of children affected by HIV/AIDS in three provinces of South Africa.[1] By combining findings from two studies that focus on households at different stages of impact, the paper looks at the conditions of vulnerable children living in homes with HIV positive family members; children at risk of becoming orphans (i.e., children living with HIV positive primary caregivers); and children 'orphaned.' It also considers the conditions of other household members affected at each of these stages. The paper is concerned with understanding more about their daily lives, and about informal and formal forms of support available to them at each of these stages.

With a population of almost 45 million people and an estimated 5.3 million people infected of HIV, South Africa, has the largest number of individuals living with the HIV virus in a single country. By the end of 2003 the prevalence rate among adults (15-49 years of age) in South Africa was 21.5 percentand among pregnant women 27.9 percent. The rate of infection varies widely among South Africa's nine provinces. The highest was in KwaZulu-Natal with 37.5 percent and the lowest in Western Cape with 13.1 percent (both provinces are included in our studies).[2]

Children orphaned by AIDS are found virtually in every country across Sub-Saharan Africa. An estimated 12. 3 million children have lost one or both parents to AIDS in the region (Deininger et al. 2003; Birdthistle, 2003; UNICEF 2004; UNAIDS 2004). Simulations infer that the numbers are still higher and that mortality rates will reach a plateau only by 2020, with expectations of stabilization by the year 2030. The hardest hit country in the region in terms of orphans is South Africa with both the percentage of children who are orphans and the absolute number of children who are orphaned rising dramatically. A recent analysis by UNAIDS/UNICEF/USAID (2004) estimates that in South Africa, out of a total of 17 million children under 17 years of age, 13 percent or 2.2 million are orphans. The number of orphans due to AIDS is estimated to be approximately half of that figure or 1.1 million. Of these children, an estimated 740,000 are maternal orphans; 570,000 are paternal orphans and 290,000 are double orphans.[3] Meintjes et al. (2003) estimated future number of orphans from two models: the Actuary Society of South

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[1] In the Eastern and Western Cape Study, study households had independently confirmed HIV+ status (see section 2). In the Western Cape study, households were not asked, and only in some cases volunteered, whether the orphans deceased parents had died from AIDS. However, we feel it is safe to assume that this was the case in many and probably most of the households, and that the information gathered on orphans in the study households provide insights into the conditions of AIDS orphans in the region.

[2] Other important estimates are for women (15-49) living with HIV, at 2.9 million (range: 2.5-3.3 million) and AIDS related deaths (adult and children) at 370,000 (range 270-520 thousand). Over the last four years, consecutively, the rate of HIV infection for young people below the age of 20 has stabilized (Dorrington et. al. 2002; UNAIDS 2004; 2005).

[3] Maternal orphans are those children under the age of 15 -or 18 in some contexts- whose mothers have died. Paternal orphans those children whose fathers have died. Double orphans are those children without either living parent (Levine 2001).

Africa's ASSA2000 AIDS and the Demographic model, and the ASSA Orphans model. They found that the number of children orphaned by AIDS is expected to peak at 2.7 million in 2016. [4]

With the emergence of HIV/AIDS as Africa's most prevalent health crisis, the term orphans and vulnerable children (OVCs) is increasingly being used to refer to children made vulnerable by the impacts of HIV/AIDS. Research on OVCs in Africa has primarily focused on conditions of, and interventions to support, orphans. Studies to date highlight the vulnerability of orphans to the HIV virus and impacts of AIDS. Hallman (2004) shows that controlling for wealth and other factors, orphanhood confers added risk for unsafe sexual behaviors. Orphans are likely to be more food-insecure, more malnourished, and less healthy than non-orphans (Ainsworth and Semali 2000; Gertler et al. 2004; Deininger et al. 2003). However, recent studies show that orphans are not more likely to be malnourished than non-orphans (Mason et al. 2005). Many studies have reported the negative effects of HIV/AIDS on children's schooling (Urassa et al. 1997; Gilborn et al. 2001; Yamano and Jayne 2005; Deininger et al. 2003). These studies show that the impacts of adult death on children is mediated by the type of orphanhood (maternal or paternal), gender and of the child and the initial conditions of the households. Therefore, context specific understanding of pathways through which adult illness and death impacts children becomes crucial. A small body of work focuses on what strategies improve the well-being of children impacted by HIV/AIDS. Deininger et al. (2003) showed that after the adoption of universal primary education in Uganda in 1997, being a foster child no longer impeded access to education. In the absence of proactive policies, however, young foster children's access to health services worsened over time. School feeding has been seen to keep children in school in Zimbabwe. In a study of food-insecure households, 25 percent of children had dropped out of nonfeeding schools in the previous year, compared to 15 percent where school feeding was in place (SADC FANR 2003).

Most recommendations focus on building on existing structures within communities, such as self-help groups, women's groups, and church groups (Nyambedha et al. 2001). Ainsworth and Semali (2000) in Tanzania found that immunization against measles, oral rehydration therapy, and improved access to health care can disproportionately improve health outcomes among poorest children, and, within that group, particularly among children affected by adult mortality.

Relatively fewer studies, however, has focused closely on the experience of children made vulnerable by HIV/AIDS but not yet orphaned[5] (Meintjes et al 2004; Giese et al 2003). That is, most of the work referenced above on orphans in Africa focuses primarily on the downstream impact of orphanhood due to adult mortality and very little on the upstream experiences of

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[4] Conversely, the number of children orphaned for other reasons other than AIDS, is expected to decline which is in line with falling fertility rates. Other estimates predict the rise of maternal orphans by each province in South Africa, which would account to 3-4 percent in the absence of the AIDS epidemic, however, with the impact of AIDS the proportion of children maternally orphaned can rise to 20 percent, with the highest percentage for KwaZulu-Natal, the Free State and Mpumalanga.

[5] Although the some of the above studies focus on children in communities with high HIV prevalence rather than orphans per se, focus on children at risk of orphanhood is generally sparse in literature. An exception is Giese et al. (2003), who are concerned with the social needs of children living with sick adults, observing, inter alia, that social workers were not assisting caregivers to plan for their children's future, nor directing services at children living with sick adults, two clear social needs.

children before they are orphaned. Orphaning in the context of HIV/AIDS is a process that begins long before the death of a parent. HIV positive parents, their children and other caregivers face different challenges at different times along the continuum of morbidity, mortality and orphanhood. For children, death of a parent or sibling is an experience that could potentially change their life forever. Often the trauma of death due to terminal illness starts well before the death of a loved one, as is the case with death due to AIDS. It is incurable and the treatment, if available, often not accessible. Therefore, it is often accompanied by fear. In addition, stigma frequently accompanies illness and death related to AIDS. Children as well as adults may remain silent for the fear of being ridiculed or ostracized. This may prevent parents and children accessing resources that may strengthen capacities of children to deal with challenges posed by illness and death of an adult in the family. Another unique aspect of HIV/AIDS is the clustering of death within households. Multiple and serial illness and deaths within families means that children in these households may be overburdened, may be forced to move from home to home, community and school. Children may feel guilt, fear and abandonment. They often shoulder new roles and responsibilities, in addition to their existing ones. Understanding of the trajectory of experiences of children before and after they experience death of their parents in the dynamic context of HIV/AIDS is largely missing from current research and policy perspectives. Also missing is how HIV positive parents anticipate and plan for children's future.

In South Africa, research on the 'downstream' dimension of OVCs—orphans—has so far looked statistically at numbers and predicted numbers of orphans (UNICEF 2004; Meintjes et al. 2003; Birdthistle, 2003); impacts on schooling (Case and Ardington 2004; Cichello 2004); interventions (Richter et al. 2004), fosterage patterns (Madhavan, 2004), mobility patterns and migration (Hosegood and Ford 2003); social consequences (Brady 2003) and state policy with particular reference to the Foster Care Grant (Meintjies et al. 2004). But this is still a relatively new field of research in South Africa, compared to that on other dimensions of HIV/AIDS or child poverty, and it is still difficult to draw conclusions about the more broadly-defined conditions and needs of orphans. Some of the implications of this research is somewhat at odds, e.g., around the issue of discrimination against orphans. Our research attempts to shed some new light on their conditions in their changed households, their experience and that of their caretakers. It also focuses on the issue of interventions aimed at assisting OVCs—finding—in contrast to many other parts of Africa—a substantial but widely inaccessible Foster Care Grant, and a near absence of any other interventions by the state or NGOs. In discussing OVC interventions across Africa, Richter (2004) argues that in Africa there is a 'collective ignorance' on the impact of AIDS affecting children and families and that information seems to be scattered and available in what they call 'pockets of local knowledge'.

This paper thus contributes toward filling in two knowledge gaps—one on children vulnerable to becoming orphans and another on those already orphaned—using two different data sets of in-depth household interviews from three provinces in South Africa—Eastern Cape, Western Cape, and KwaZulu-Natal. It would have been most desirable to track the same children before and after their experience of adult mortality to understand the trajectory of experiences, but given the background of the two studies (see section 2) this was not possible. Instead we use two cross-sections of children from two different data sets. The first data set primarily focuses on children living with an adult of known HIV positive status (soon to be orphaned); the second data set focuses on children already orphaned.

Adult and Child Mobility in the South African Context

For both studies, historical and current family structure and mobility patterns are key themes shaping the questions of inquiry and interpretation of the research findings. Apartheid legislation had powerful and long-lasting effects on family structure in South Africa, especially for the African population.[6] Under the Influx Control Laws (repealed in 1986 but gradually subsiding), Africans were relocated to "homelands," with severe restrictions on their ability to travel or find work (Beinart 1994; Jones 1993). Africans living in cities were restricted to townships, small ghettos that generally had inferior housing and public facilities (Jones 1993).

Apartheid legislation contributed to a shift to increased complexity in household organization among Africans (Van der Waal 1996; Niehaus 1994; van der Vliet 1991). South African adults were often forced to seek employment and to live apart from their spouses and families. As a result of migratory labor patterns and restrictive housing options, women often became *de facto* heads of household. Many households came to depend heavily on financial remittances sent in from family members employed elsewhere (Leibbrandt et al. 2000, Posel 2001, Spiegel et al. 1996). In part due to these migratory labor patterns, divorce and non-marital births increased greatly for Africans during the apartheid era (Burman and van der Spuy 1996).

Migratory labor patterns meant that one or both of a child's parents were often not present for much of the year, even if they were considered to be current members of the household (Case and Deaton 1998; Siqwana-Ndulo 1998). Parents began to rely increasingly on family members other than spouses for support with the household economy and with raising children (Madhavan 2004; Van der Waal 1996), and rates of child fostering increased (Gordon and Spiegel 1993). Thus, there is a long-history in South Africa, especially among Africans, of children being parented by women (e.g., aunts and grand mothers) if their own mother is absent for periods of time, at least for periods of their lives (Meintjes et al. 2003). Widespread practices of kin fostering; Zulu cultural norms that make out-of-wedlock children part of the maternal family; the frequent unknown status of the father; and widespread work-driven migration leaving children indefinitely with relatives all have led to children experiencing the "death of a social parent" even where biological parents may be alive (Zhuwau 2005). The concepts of "social parenting" vs. "biological parenting" and the implications of this distinction in the context of an orphan crisis in South Africa has thus become a debate in South Africa.

While social parenting is not a new concept to South Africa, HIV/AIDS brings with it specific challenges—stigma, discrimination, high costs of medical care, premature death of primary caregivers and clustering of deaths in households. The situation of children in this context can only be understood through a systematic study of household mobility, kinship and the context of fosterage. Maadhavan (2004) makes a useful distinction between voluntary fostering and crisis-fostering. The former refers to informal fosterage that accord with cultural norms about child rearing. Crisis-led fostering pertains to fostering done in response to a crisis—mostly death of biological parents or economic hardship. While crisis-led fostering more accurately describes the situation of children fostered to cope with impacts of HIV/AIDS, this process is articulated with

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[6] We use the term "African" to refer to black South Africans of African origins. Although this was an apartheid racial classification, it is still generally used when needed to distinguish between groups with distinct cultural and political backgrounds, when such distinction has relevance for the subject at hand.

historical patterns of voluntary fostering. The conditions of OVCs in South Africa, and the findings and conclusions of our research on this topic, can only be understood in relation to these processes.

Section 2 describes our study sites, research designs, methods and data. Section 3 presents the results of the Western Cape and Eastern Cape studies, focusing on children's mobility and inter-household linkages; the roles of children in HIV/AIDS affected households; disclosure to children; and planning for children's welfare and security. Section 4 presents results from the KwaZulu-Natal study, focusing on who fosters orphans; issues and processes around decisions to foster; and experiences of orphans in fostering households. This section also looks at the conditions of child-headed households. Section 5 presents results from the KwaZulu-Natal study that look at interventions; including informal and formal types of support; including cash grants as well as multi-dimensional forms of support. Section 6 considers policy implications and draws some conclusions and recommendations.

2. Research Sites, Methods, and Data

This paper is based primarily upon two studies using qualitative research methods. Both were part of larger studies that also included panel surveys, thus integrating quantitative and qualitative research methods. The first study, focusing primarily on vulnerable children not yet orphaned, took place in Western Cape Province and Eastern Cape Province, and was part of a larger prevention of mother to child (PMTCT) cohort study. The South African Department of Health supported School of Public Health, University of the Western Cape, the Health Systems Trust (a local NGO) and Medical Research Council to jointly conduct PMTCT cohort study.

The second study, focusing on orphans, took place in KwaZulu-Natal Province. This was associated with a panel study on poverty dynamics conducted in 1993, 1998, 2001 and 2004, by the University of KwaZulu-Natal, IFPRI, and several other institutions (see Adato, Carter and May. forthcoming; Carter and May 2001; May et al. 2000). It was conducted with a small sub-sample of the panel survey households, and involved new qualitative modules that had not been previously included.

2.1 The Western Cape and Eastern Cape Studies

Sampling Framework

The original aim of the study was to build upon a cohort of women who participated in the evaluation of a prevention of a mother-to-child transmission (PMTCT) trial and whose HIV status was already known. The PMTCT trial was initiated in 2003 (Jackson et al. 2004). Recruitment and initial home visits were conducted across the two sites with a total of 400 mother-child pairs identified (of whom 300 are positive and 100 are negative). Our aim was to purposively sample PMTCT mothers who were experiencing HIV/AIDS-related ‘shocks’ which we defined as AIDS-related mortality, prolonged illness, or where children from outside of the home had been taken in due to an AIDS-related death of the parents to study the response strategies households adapt to these shocks. While this was possible in in the Eastern Cape site, in the Western Cape site the majority of the PMTCT women are relatively healthy pregnant women that learnt of their status when they were enrolled in the PMTCT trial and were not yet experiencing any of the above mentioned impacts/shocks related to HIV/AIDS.

Therefore, we altered our sampling strategy in Western Cape to enroll HIV positive women, who may or may not be a part of the PMTCT trial, but are aware of their status, and experiencing HIV/AIDS related impacts at the household level as mentioned above. In Western Cape we utilized three sources to select our respondents. The first source was that of Ikhwezi, a local NGO working in Mbekweni to support households who are caring for AIDS-orphans. The second contact was the Mbekweni Community Health Project. The Community Health Workers (CHWs) at the site are aware of the most vulnerable in the community and are in regular contact with many women who are impacted by HIV/AIDS. The last is a Sister at Paarl General Hospital who is also a fieldworker on the PMTCT study.

The Study Sites

Western Cape Province: Paarl, Mbekweni and the Drakenstein District

In Western Cape, the study was conducted in the township of Mbekweni, about 10 minutes outside of the town of Paarl. The majority of people are Xhosa speaking Africans and are unemployed or seasonally employed on nearby grape farms. Paarl is a peri-urban/rural commercial farming area in Western Province with pockets of poverty and poor health. Despite its relative wealth, the socio-economic statistics of the municipality demonstrate immense poverty and extreme deprivation amidst immense wealth (Drakenstein Municipality 2004). The Infant Mortality Rate (IMR) in Paarl is around 40/1000 live births, however the rate in Mbekweni is most likely higher. HIV prevalence rate is fast escalating in Paarl. The District Antenatal Survey of the Provincial Department of Health shows that the HIV prevalence increased from 4.5 percent in 2000 to 15 percent in 2004 (Drakenstein Municipality, 2005).

Eastern Cape Province: Umzimkhulu District

In Eastern Cape, the study was conducted in Umzimkhulu, which is one of the poorest rural areas of South Africa, the former Transkei homeland in the Eastern Cape. Although part of the Eastern Cape, it is bounded on all sides by KwaZulu-Natal. Due its unique geography, the language most widely spoken in the region is a mixture of Xhosa and Zulu**.** Employment levels are very low, with only about 12 percent of residents in the municipality employed. There is a marked dependency on government services, pensions and migrant workers, with 38 percent of households reporting no income at all. Only half of the population is literate. Umzimkhulu is one of the previously neglected former Transkei districts with poor health facilities. There are 14 clinics, of which only two are in new, permanent structures. The IMR is 99/1000 live births. The antenatal HIV prevalence rate is 28 percent (Department of Health, 2005).

Data Collection

In both communities, introductions were made with potential respondents through local contacts. Potential respondents were either phoned or visited with our local informants and told about our study. If they agreed to participate, an appointment time was arranged. In almost all cases the researchers were personally introduced to the participant by local personnel. If they agreed and were comfortable, the researchers would introduce themselves, explain their positions and affiliations, the research they were conducting, and request their formal consent.

Our final sample consisted of 25 respondents from 20 households. HIV positive women and/or primary caregivers (PCGs) of orphans were our main respondents. Where circumstances permitted, we also interviewed other household members to better understand response strategies to HIV/AIDS. We also interviewed four key informants in each of the communities. Open ended in-depth interviews guided by a semi structured field guide was the main mode of data collection. Data was analyzed using NVivo qualitative data analysis software. Pseudonyms were used to protect confidentiality.

More than half the respondents were interviewed in their homes. When logistics allowed, participants were given a choice between conducting the interviews in their homes or at alternative locations such as the Mbekweni Community Health Project, Ikhwezi, the clinic, or the hospital. In most cases where alternative locations were chosen, it tended to be a question of logistics for the respondent than a matter of stigma or fear for us visiting at home. We found no difference in attitudes or comfort levels between those conducted at homes and other locations. This was most likely due to the fact that the alternate locations were not unfamiliar to the respondents but were places they had visited in the past.

For the purpose of this paper analyzing the support to children at risk of orphanhood, we utilize data from mothers and primary caregivers from 19 households that have children below 18 years of age.

2.2 The KwaZulu-Natal Study

Sampling Framework

Out of 67 clusters[7] in the KIDS 3 survey, six were chosen for the qualitative study. This number was kept small in order to allow us to collect data of sufficient depth on four different research themes (orphans, the Child Support Grant, home-based care, and changing household structure and livelihoods) within the study time frame. Data collected in preparation for the KIDS 3 survey in 67 communities was used to select the six qualitative study sites. The clusters selected were to be stratified on the following variables: 1) rural/urban; 2) geographical spread; 3) degree and types of activities (mainly presence but in some cases absence) pertaining to the four research themes. Two of the six clusters were also selected because they had been part of a qualitative study by UKZN/IFPRI in 2001, and we wanted to follow up with some of the same households three years later. Telephone interviews were conducted with local leaders from as many of the survey clusters as possible, obtaining information on variables under (3) above, and a final six clusters selected.

Within each of the six selected clusters, six households were selected, with each research theme covered in three of these clusters, and two themes covered per household. This struck a balance between not overloading the fieldworkers and respondents with too many modules per household given the limited timeframe, while also enabling us to capture some interaction between the themes. Because we want to be able to compare quantitative and qualitative data, the first household selection criterion was that they be KIDS 3 survey households; within these, the second criterion was that the household had to contain a pair of conditions to enable data collection on two themes: for example, have a CSG; foster at least one orphan; have a person with a chronic illness. The livelihoods theme enabled the selection of any households. Since these two criteria normally exhausted the supply of households, an additional criterion was not necessary; where it was however, the selection was made purposively.

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[7] "Clusters" refer to a census units that have been used in the KIDS panel surveys. These are sometimes equivalent to a small locality, and may be sometimes be loosely construed as "communities." However, given the variation in clusters and the complexity of the term "community" we normally use refer to "clusters."

Study Sites

KwaZulu-Natal is South Africa's most highly populated province, with approximately 20 per cent of the country's population. Eighty per cent of the population is Zulu-speaking. Nearly half of the population lives in urban areas, but a far larger proportion of the African population is rural-based than is the case country-wide. It is among though not the poorest province, but is argued to have the highest incidence of deprivation in terms of access to services and other measures of well-being (Klausen 1997; Woolard and Leibbrandt 1999). It has the highest incidence of HIV infection among the nine provinces, with an estimated infection rate of 37.5%. In 2005, KwaZulu-Natal was among the two provinces with the highest percentage of children who were maternal orphans, at approximately 10 per cent, and predicted to rise to approximately 20 per cent by 2012 (Meintjes 2004:32-33).

Using the criteria described in earlier, the following sites in KwaZulu-Natal were selected for the ethnographic study. In the south, Ndaleni and KwaDunuse; in the north, Mpakama and Kwabrush. The large urban township of Umlazi (L Section) located outside of Durban on the east coast was also selected, as was the urban area of Osizweni near Newcastle in the West of the province. Kwabrush and Mpakama are rural localities, although as in much of South Africa, the rural-urban distinctions are blurred, with KwaDunuse and Ndaleni considered rural but with some urban characteristics. There are variations in infrastructure and services; for example, Ndaleni has relatively good services while KwaDunuse is poorly serviced.

Data Collection

The first preliminary data was collected from telephone semi-structured interviews with local leaders in the survey clusters (except where they could not be contacted). The main purpose of these interviews was to obtain information for the purpose of stratifying the sample and then selecting six study clusters, but information from 21 clusters with substantial enough information on interventions was analyzed and reported on in section 5 below. As noted above, six clusters were selected for the case study research, but an additional key informant interview was conducted in an additional urban area, KwaMashu near Durban, when no formal or informal interventions supporting orphans could be identified in Umlazi section L, and an interesting intervention identified in KwaMashu.

For the six clusters chosen for the main study, permission to conduct the research was obtained from various local leaders. Consent was then obtained from the six case study households selected, after explaining the background and purpose of the study and assuring confidentiality. A 'modified' extended case study method was chosen for the study.[8] This used household case study techniques including formal and informal interviews conducted during repeated visits to the study household homes, and observation of activity within the household, community, and other points such as welfare offices. Key informant interviews were also conducted with individuals such as teachers, nurses, local authorities, people who run local livelihoods projects, pension committees, and others. Three fieldworkers conducted the research over a six-month

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[8] The term 'modified' was used because the period in the field and the period with each case study household was shorter than is most often the case using an 'extended case method' (Burawoy 1998). Also, fairly structured interview guides were used, primarily because of the low level of experience of the fieldworkers.

period in 2004, with each person living for two months in each of two communities, staying in the field for a month at a time and alternating communities and periods back in Durban to process field notes. Data was analyzed using NVivo qualitative data analysis software. Pseudonyms were used to protect confidentiality.

This paper also draws on data from the KIDS 3 panel survey conducted in KwaZulu-Natal in 2004. This included a community survey of 67 clusters and a household survey of 1,428 households.

3. Preparedness of Children at Risk of Orphanhood in the Context of HIV/AIDS: Findings from Western Cape and Eastern Cape Province

Preparing for parent's illness and death is an ongoing and iterative process for both parents and their children. The realities of HIV/AIDS-induced migration, the assumption of new roles and responsibilities due to a parent's illness, and the disclosure of HIV status of parents present challenges to children. Children must cope with prejudice and stigmatization from others, and with their own anticipatory grief due to their parent's illness; they may also experience increased anxiety for their own security and welfare. In addition to confronting stigma and discrimination, HIV-positive mothers are often concerned about issues of disclosure to children, and about planning for their future security in the face of severe financial constraints. Understanding more about the processes and experiences involved in preparing for the illness and death of a primary caregiver may help to inform polices and programs so that these experiences are relatively adaptive experiences for both parents and their children.

In this section, we begin by examining the roles that children are playing in HIV/AIDS-affected households. We then examine the ways in which mothers prepare children for their impending deaths. Here we discuss the experiences of mothers related to disclosure and how they talk to children about their future. Finally we investigate how mothers plan for their children's future welfare and security.

3.1 Children's Mobility and Inter-Household Links

Many researchers have investigated household structure and mobility in South Africa. However, there is a dearth of studies on the living arrangements of children in households affected by HIV/AIDS. This section describes the dynamics of mobility of children affected by HIV/AIDS.

For the purpose of our research, we asked the mothers/primary caregivers to list the members of their households, recognizing that the terms "household" and "family" are subject to much conceptual confusion, especially in Africa (see Spiegel 1996 for discussion).

Our qualitative data on household histories (household with children<18 years of age) show that only a minority of families ever attained long-term residential independence. Among the household histories, nuclear families were both few and ephemeral, a result of the unavoidably dominant pattern of economic migration. In the context of the HIV/AIDS epidemic, the premature death of a partner also rendered the nuclear family unviable. Relationships between households were complex, indicating their mutual interdependence. Many households in our sample included a variety of co-resident relatives, among them orphans fostered formally or informally.

Now we turn to the living arrangements of children in our sample households and alternatives sought to ease the burden of childcare in the context of HIV/AIDS.

Most children in our households are residing with their mothers, owing to the purposive selection of HIV positive women in order to understand the vulnerabilities of children at risk of orphanhood. Thus, the core members of our sample households are a woman and her children. Fathers of children are noticeably absent from our sample households. Of the nineteen mothers/PCGs considered for this analysis, eight of them reported that the father of the children (and/or their last partner) had died of AIDS. Seven more reported that the father of the children (or their last partner) were living elsewhere. In our sample, only one 16-year-old girl child of a mother in Umzimkhulu lives with her father in another village, as the mother cannot afford to send her to school. Only one household in our sample had a male head of the household (father of the children) living in the household. While absence of partners/father of children in the households is not uncommon either in Western Cape (Spiegel et al. 1996) or Eastern Cape (Siqwana-Ndulo 1998), we find that the frequency of such absence is higher in our sample than in other studies, revealing the deepening of existing vulnerabilities of children due to HIV/AIDS in South Africa. Previous research in South Africa, described in Section One, shows that households headed by women are more likely to migrate or dissolve. Children in female-headed households are significantly more mobile than children in male-headed households.

Change in residence of mothers and their children often resulted from marital discord and breakdown, a recurring theme among our sample households. Out of 17 mothers in the sample (excluding one-sibling headed and one grandmother-headed household), 12 mothers were married. The widowed mothers in our sample often reported that marital breakdown began even before the death of their husband. Abandonment was high--most often due to discord related to the HIV status of the partner. Often, too, the relationship with in-laws was affected negatively. Of the 12 married mothers, seven reported having very negative relationships with their in-laws, before or after the death/abandonment of their spouses. Mothers experiencing marital breakdown (and/or death of their husbands) in our sample were thus under pressure to leave their marital homes. Only two previously married mothers continued to reside in their in-laws house/homestead after the deaths of their husbands. One of them had a bad relationship with her in-laws and wished to move out. The other mother had very good relationship with her in-laws and will continue to reside with them. When mothers moved out of their marital homes, children accompanied them. Mothers and their children most often moved to the homes of their mothers/siblings as a response to the burdens of economic hardship and child rearing responsibilities. The following excerpt from a household interview exemplifies some of these issues:

> In 2002 she began treatment for HIV. Her husband chose not to get treatment. After this break in their decisions things were never the same. Currently he is sick and not going for treatment. He also has not disclosed to his family. In fact, she disclosed for all of them (herself, him, and her child) to his family in the Eastern Cape. She took her husband to court in order to get maintenance from him and now she does collect this money.
>
> She is separated from him but not legally and not divorced. She attributes her financial survival to the fact that she can live with her mother and not pay rent. Her sister sometimes watches her youngest child so that she can attend support groups and other meetings. (*Neliswa, mother of two children*)

While moving into maternal homes is a common response strategy, this was not always not the case. The one sibling-headed household in our sample is an illustration of such a case. In addition, half of the mothers in our sample, after parting with their spouses/partners or their mortality, lived by themselves with their children.

Interestingly, children of mothers that are not married (there are five of them in our sample), seem to have experienced less mobility. Such mothers in our sample tended to live in their maternal homes and maintain *status quo* after they separated from their partners.

In some cases of paternal death and abandonment, to ease the economic and care giving burdens, children were sent away (children of six mothers in our sample), mostly to matrilateral relatives. These cases of informal fostering of children almost always resulted separation of siblings. The ages of the children that migrated from our sample households ranged from 15 months to 17 years. Children migrated mostly to grandmothers who were often the recipient of old age pension (3 of them). Two mothers sent their children to their maternal aunts. As one key informant noted "*they (maternal aunts) will have the most invested in the children- they are the most like their mothers as well".*

> She has two children (daughters) who are 7 and 2 years old. The fathers of both children are different and neither is very supportive financially. The father of the 7-year old left when the child was only 8 months old. The father of the 2-year old is not supportive although he is supported by a Disability Grant because he is sick with TB (Tuberculosis). Her 7-year old child lives in the Eastern Cape with her aunt. She sent her child away because she couldn't afford to keep her. It was better to send away her eldest child because she has more needs and it is less expensive to keep her younger child. Both children receive CSG. The aunt of the older child receives the grant for care in the Eastern Cape. (*Zoliswa, mother of two children*)

Sending children to live with relatives is also a mechanism to ease the care giving burden of the HIV-positive mother when she is ill. The response of this mother of four children between the ages of 15 months and 17 years reemphasizes the role children's migration plays in coping with the challenges posed by HIV/AIDS:

> The baby moved from the household (at 12 months) to stay with the respondent's sister when she became very ill and was having difficulties looking after her. Also, because her own children were still attending school, they were unable to assist her and so her sister took the child in. She does plan on fetching her daughter and bringing her back when she is feeling better. Her sister does bring her baby quite often to see her because she asks her to. (*Mafu, mother of four children*)

Fostering is also common among our sample households. Four households in our sample fostered children (excluding one sibling-headed household). Three households received maternal orphans due to AIDS, further reinforcing inter-household links and their mutual interdependence under severe economic strain (Box 1).

It is beyond the scope of this study to investigate the adaptations a young and dependent child has to make when they migrate. From our study, we observe that the circumstances of households in our sample require children to accustom themselves to relatively fluid, non-exclusive filial bonds. Relationships with matrilateral kin are of particular importance for children in our sample because these relatives often act as substitute parents. As Van der Waal

(1996) notes in a study of the mobility of children in Berlyn "*from a young age, children thus learn not to find their physical , social and psychological security exclusively with their parents*" (page 46).

Box 1 A spirited grandmother's story

Thandiswa, 65 is a pension recipient residing in Umzimkhulu. She lives with her daughter who is self-employed and has 2 children, ages 11 and 8, both of whom are attending school. She has also taken in two of her grandchildren whose mother passed away in 2001. The eldest is a girl, 15 years old, and the youngest is an 11-year old boy, both of whom have also remained in school. There are also 2 more grandchildren whose mother also passed away in 2001, and she has taken in these children as well.

The family livelihood subsists of her Old Age Pension, Child Support Grants for the two youngest children, and the earnings she and her daughter receive from selling chips at the local school as well as from their home. She is also supported in small ways by her granddaughter who is now a teacher. From this she has also been able to become a member of a savings club and is one day hoping to have enough money to build a house for all of these children to live in. She would really like to help her granddaughter who is currently matriculating to study further but has no means.

Thandiswa is a prime candidate for the Foster Care Grant and is in need of the extra income it would garner. She was told about a grant that is given to people who take care of orphans by somebody that she goes to church with. Indeed, she tried to apply for this FCG. She went to the social workers with the documentation such as the death certificate of the mothers but she was told the children were not eligible as their fathers were still alive. The social workers told her that both parents had to be dead in order for her to get the grant

Thandiswa's story is one of immense resilience in very difficult times. Hers is a story the government of South Africa needs to hear in order to address the complex realities of childcare without the support of men. The rigidity of the system is what will fail Thandiswa's granddaughter in her efforts to further her education.

3.2 Present Roles of Children Living in HIV/AIDS-Affected Households

The various roles and responsibilities children bear in and outside of the home in resource-poor settings is well recognized. In South Africa, the 1999 Survey of Activities of Young people (SAYP) states that 45 percent of all South African children are involved in some form of 'work' if a broad definition of work is used (Bray 2003; Statistics South Africa 2001). Fetching water and wood was the most common 'economic activity' (62 percent) followed by help with farming (15 percent) and 'unpaid domestic work', meaning household work by children living in households without parents or grandparents (7 percent). About 12 percent of South African children are engaged in domestic chores seven or more hours per week. A trend in increasing engagement with age emerges from this survey. Using Time Use Survey (TUS) , the Cape Area Panel Study (CAPS), and ethnographic methods, Bray (2003) investigates concerns around the levels of household chores by children and implications for their well-being. The study shows heterogeneity between boys and girls across different age categories and between urban and rural areas.

In South Africa, examining participation of children in work requires viewing their work as a function of their roles as members of households and as an opportunity to learn new skills required in adulthood. However, concern over work in childhood is increasing the light of HIV/AIDS. There is some evidence from South Africa that children living in communities where AIDS is exacerbating chronic poverty are undertaking a larger share of household work and missing school (Booysen and Arntz 2002; Giese et al. 2003). Our qualitative study adds to understanding of the experiences and roles of children in HIV/AIDS-affected households.

For this analysis, we include data from only those mothers/PCGs that have children eight to 18 years of age residing *in* the household. The rationale for this is that by the age of 8, children are often lending support to their families whether in the form of emotional support, care giving, or through financial assistance. Of 11 households in Paarl, nine were characterized as such, while four of six in Umzimkhulu included children 8 years of age or older.

Children as Caregivers: Care, Support, and Assistance in Treatment

Our interviews reemphasize the continued role of children in performing routine chores such as those mentioned above. Almost all of the mothers/PCGs with older children residing in the household mentioned their children performing domestic duties. This was especially the case for female children as they were depended upon for the care of younger children.

An assessment of care giving activities performed by children is important to deepen our understanding of roles children perform in response to rising rates of AIDS-related illness and death in the household. Bray (2003) finds that far fewer African and colored children engage in care giving activities than other domestic tasks. She finds that in Masiphumele, where HIV prevelance is high, "*female relatives living close by or in other parts of Cape Town, and/or neighbors are their first port of call*" in times of need for childcare. While female relatives were an important port of call, our study also shows that as HIV-positive primary caregivers attend support groups, apply for grants, and visit clinics and hospitals, older children, especially girls, are increasingly taking on the primary care giving responsibilities of their younger siblings. The experience of the mothers in Box 2 and Box 3 below demonstrates how the traditional role of care giving by older children is assuming a heightened importance in the era of HIV/AIDS.

Box 2 Children providing care and support to their HIV positive mothers/PCGs

Lolo is a mother of eight children—six sons and two daughters. Their ages range from 22 years to 3 years. Her 22 year old son lives with his uncle. Her 15 year old daughter is in standard 4 and lives with her paternal granny in Eastern Cape. The three-year old boys are twins and are HIV positive.

Her mother passed away in 2003. Her mother used to assist her as well. She would get remittances from her from the Eastern Cape. She does have a sister and brother but they do not assist her at all. Her sole source of income is the Child Support Grant that the twins get. Her eldest daughter (19 years old) is also very helpful with other children. If she were to get sick or if anything happened to her, she thinks that her daughter would be able to look after her other children. There have already been days where she has done this.

A domestic role unique to HIV/AIDS-affected households is that of providing treatment support. Our study shows that both boys and girls are increasingly playing important roles in helping their mothers follow treatment regimens (Box 3). Such support is critical in adherence to antiretroviral (ARV) regimens (Murray et al. 2004; Simoni et al. 2002). Non-adherence allows the virus to resume rapid replication resulting in multidrug resistant strains that can endanger health of the individual on ARVs as well as the health of the public should transmission to others occur.

Box 3 My daughter acts as my buddy

Rose's husband passed away in 2002 from AIDS. She has two sons (ages 11 and 4) and a daughter (age 13). She works as a domestic worker. Her youngest child receives CSG. She is also a recipient of Disability Grant. When her husband died, her mother came to live with her. She is not emotionally supportive or in any other way.

If she needed someone to watch the children it would be her eldest child and not her mother. She and her daughter are very close. Her daughter knows about her status, found out while listening to a conversation between her mother and her brother-in-law. The daughter cried a lot when she first overheard the conversation. But now, she and her daughter are very close. Her daughter often reminds her to take her tablets. She comes home from work and is often very tired and will fall asleep. Her daughter wakes her up after work and reminds her—she acts as her buddy.

Perhaps one of the most important areas where boys and girls are providing their HIV-positive caregivers with support is that of emotional comfort and love. No matter the context, an HIV - positive status is a difficult reality. In South Africa stigma remains a barrier to support. Treatment is not yet a viable option for many resource-poor people, despite the rollout of ARVs. Emotional support and comfort remain the most important factors for stability, optimism, and overall positive living of those living with HIV/AIDS. Mothers/PCGs in our sample found children to be a critical source of emotional support, making it easier for them to face the daily tribulations of being HIV positive—as Lolo states, "*The fact that my children are handling my [HIV] status well makes it easier for me to deal with stigma".* Such support has may have important implications for longevity of mothers/PCGs. There is evidence that perceived support from family members positively influences health outcomes of HIV positive men in the United States (Serovich et al. 2000; Kalichman et al. 2003).

The stress of giving care to a terminally ill person is well recognized. Adolescent children could be especially under stress. Adolescence is a time of rapid change—both physically and emotionally. Children now not only have to deal with their individual changes, but also take on the onus of supporting adults. Neliswa's experience is a window into the strain adolescents in these households may be going through. Neliswa is a mother of two in Paarl. She disclosed her status to her 18 year old son. Although her son seems to have accepted her status, she and her son have strained relationship. They have not spoken much to each other lately. She states, *"I do not attribute this to my status but to normal teenage problems."*

Like other studies, children in our sample are not the primary or secondary sources of monetary support. Only one mother in our sample cited her son to be a *potential* source of support. This could be due to high adult unemployment rates in South Africa that prevents young people from finding work. In contrast to other literature investigating the impact of HIV/AIDS on children's well-being in South Africa (Booysen and Arntz 2002), we find that very few children in our sample dropped out of school. None of the mothers/PCGs reported their children missing school due to economic activity. The most important reported constraint on schooling is school fees. Our findings indicate that mothers/ PCGs prioritize children's education over domestic chores and economic activity.

3.2 Experiences of Disclosure to Children

The increasing care giving responsibilities being placed on children's shoulders presents HIV-positive parents with the immediate dilemma of whether to disclose their HIV status to their children. Previous work from developed countries in this area suggests that women are most likely to disclose to their close friends, mothers and romantic partners (Armistead, Morse, Forehand, Morse, and Clark 1999; Simoni, Demas, Mason, Drossman and Davis 2000), finding disclosure to their children to be the most difficult (Semple et al. 1993; Tompkins, Henker,Whalen, Axelrod and Comer 1999). In these studies less than one-third of the mothers disclosed their status to their children.

Disclosure of HIV status of parents to children is critical for preparing children for impending parental illness and death. Evidence shows that open discussions about illness and anticipated loss have been shown in some studies to lead to more fulfilling family relationships (e.g., Brown and Powell-Cope 1993) and children's misconceptions about their mother's health will likely persist if such discussions do not occur (Siegel and Gorey 1994).

Disclosure is crucial for children to be effective agents of response and yet has been largely ignored in the literature from Africa. This section illustrates some of the experiences of mothers in disclosing their status to their children, and the importance it may play in child preparation and well-being. Understanding more about factors that are associated with mothers' disclosure to their children may foster efforts to guide disclosure decision-making, as well as increase the likelihood that when disclosure occurs it is a relatively adaptive experience for mothers and their children.

Out of a total of nineteen mothers/PCGs interviewed, fourteen have children that are eight years of age or older living with the mother or elsewhere.[9] Some six mothers/ PCGs, (less than half) disclosed their status to their children. Our findings show that disclosure ranged from being a process to a single important event. But in almost all the cases it involved a lengthy mental and emotional preparation.

For some women, disclosing to children came relatively easy. Lolo, the mother of six children, two of who are HIV positive states *"It took me a year to disclose. All my children know about my status now. I disclosed to them alone and the children accepted it"*. Lolo's experience was not atypical in our sample. Even those mothers that stated that they could disclose to their children without much anguish took approximately a year to do so. For others, although they had

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[9] This analysis includes mothers that have children living elsewhere.

a desire to be open and honest with their children, the process represented a more difficult challenge. Two mothers also expressed concern and confusion over the appropriate age for children to know about the positive status of their parents:

> She has not yet disclosed to her 8-yr old. She doesn't think he will be old enough to understand, he is not mature enough. (*Pule, mother of two children*)
>
> She says that she will definitely talk to her son one day about her status and about HIV/AIDS in general. She has been thinking herself about when to disclose to him and feels that he is very clever and she will probably due it when he is 6 or 7. (*Tumi, Mother of one child*)

Our study confirms results from previous studies, albeit from the developed countries, that HIV infected parents are more likely to disclose to children who are older (Weiner et al. 1996; Rotheram Borus et al. 1997; Shaffer et al. 2001; DeMatteo et al. 2002). This could be because mothers/PCGs may feel that older children may be better able to understand the implications of their illness. These studies also show that parents are more likely to disclose to female children. This cannot be confirmed from our data, given the small sample when disaggregated by age and gender of the child.

Further exacerbating the difficulties of disclosure is the logistical fact that for a large proportion of South African families, children are *not* residing with their parents. The question of proximity therefore became a factor in disclosing to children, while once again no support existed to help parents overcome this predicament:

> Her children do not yet know of her status. She thinks it is possible though that her mother has told them. She hasn't really thought of telling them, in large part because they are not around each other (*Bulelwa, Mother of children age 10 and 15 years who live with their grandmother in Eastern Cape).*

The following case (Box 4) highlights the complexity of disclosure to children, especially to youth who are already knowledgeable about HIV/AIDS. It is also an example of the startegies HIV-positive people utilize in order to 'feel out' how their disclosure would theoretically play out in their closest and most important relationships.

Previous research from elsewhere shows that disclosure of HIV status may not often bring anticipated relief. These studies from Western countries have reported a significant increase in child behavior problems and a decrease in mother-child relationship quality from pre- to post-disclosure (Shaffer et al. 2001; Rotheram Borus et al. 1997). In stark contrast, in our sample, where mothers disclosed their status they did not report any deterioration of their relationship with their children. Where they were able to discuss their illness with them, the children were largely supportive. Further, in some cases the children took on key roles in the support network of the HIV-positive respondent. A prime example of this was in the sibling-headed household where the young man's mother had spoken to him prior to her death about her illness and a time when she would pass away (Box 5).

Box 4 Experiences of disclosure: 'Feeling out' disclosure to children

Bongi, 40 years old, is a mother of a 17- year old daughter. She now lives with her boyfriend. Her daughter lives with Bongi's mother at a homestead close by. At this homestead are also her sister-in-law and their three children. This homestead has a few huts and also an 8-room house where they all live. The father of her living daughter lives in Durban and is married to someone else. He helps in small ways but Bongi says it is not enough, especially to help raise a teenager. He gives her R100/month.

In 2003, Bongi gave birth to a baby daughter. At this point she still had good relations with the father of the baby, man different from the father of her teenaged daughter. The baby fell sick when her father was away on job training. Bongi phoned the father of the baby to tell him that she and baby were being tested for HIV. After that phone call she never heard from him again. When she got her results that they were positive she never told him. She never heard from the father of the child again, even at the funeral for the baby.

Bongi disclosed her HIV status to her mother and her sister-in-law. She has not told her current boyfriend or her teenage daughter.

Her daughter has bad asthma and so she is afraid that if she told her she might get sick. She also does not want her to worry about her or be devastated by her status. However, there was a time recently where she told her daughter that she was HIV positive and then said that she was joking. Her daughter told her that even if she was it would be okay because there are many other people who are positive and it is just like any other disease. This gave her hope that one day she would tell her, but she is not ready to do that yet.

Box 5 A well prepared child is a well adjusted child

His mother organized this [inheritance of the house they now live in] before she passed away. She put the house in his name so that there would be no problems when she passed away. There had been uncles who were interested in the property but there was no grabbing because she organized inheritance before her death. He did not see this as a difficult process for his mother.

He himself has now opened a Funeral Policy because he is receiving enough financial support that he has some left over each month to save.

Before his mother passed away she spoke with him about a time when she would not be around. She told him that times would be difficult and that he would have to deal with it on his own. In fact, this made things easier for him because he knew what was to come. His mother also empowered him with HIV education. Because of this emotional/educational support, he feels he has the strength to support others/his peers.

He is now very open about the subject of HIV/AIDS.

(Head of a sibling headed household, 21 years old. His mother passed away when he was 18 yrs)

In another case, the relationship between a mother, her child, and her HIV status is clearly highlighted. Not only was the more informed child better able to negotiate the illness of his mother, but in being prepared, he was able to become a key support to her:

> She has also disclosed to her 17-year old son. He is a very supportive son and will even help her with things like medications. He understands what is happening because he learns about it at school. At times she thinks he knows even more about it than she does. She worries though about what it will be like one day when he goes away to school because he has been so supportive of her. (*Mafu, Mother of four children)*

Our research shows that there are many positive implications of disclosure. While all positive mothers may have yearned to tell their children, the process was not easy. An important facilitating factor aiding disclosure to children was external counseling and support. Where mothers accessed counseling and support, they were better prepared to disclose to their children. Gugu's experience highlights the role counseling played in disclosure and acceptance by children: *She has disclosed to her two eldest children and it was not difficult for her to tell them. Both her children have gone for counseling and both children can now counsel others.*

Some mothers (e.g., Rose from Paarl), expressed a desire to access counseling to disclose to their children. The actions of the activist NGO TAC (Treatment Action Campaign) in bringing HIV and AIDS much more explicitly into the public discourse seems to have emboldened some women to discuss previously taboo subjects with their children.

> When he is old enough she will talk to him about sex. Part of her inspiration is TAC, which always says to "call a spade a spade." She wants to be open with him and tell him about condoms, etc. Things need to be given a name and spoken about (*Tumi, mother of a three year old child*).

3.3 "Talking" About Future with Children

Talking to children about their future after the impending illness/death is a critical part of preparing them to deal with the trauma of parental death and for their future roles and responsibilities. Our hypothesis was that mothers who disclosed their status to children are more likely to discuss their children's future and security with them. While no conclusions can be drawn from our extremely small and purposively drawn sample, it is interesting to note that no noticeable pattern exists between disclosures to children and talking to them about their future in our study. Bulelwa, a mother of a 10 and 15 year old hasn't disclosed to her children yet. She thinks that her 15-year old son would be capable of looking after the other child and himself. However, she says, *"I have not yet spoken to him about this. But one day I will get the guts to talk to him about it."*

Disturbingly, six out of eight mothers/PCGs that disclosed to children eight years or older, did not explicitly discuss the future with their children either. As for the orphans in four of our sample households, only one respondent of a sibling-headed household mentioned their mother explicitly talking to them about their future before her death. We could not obtain such information for the rest of the orphans fostered in three other households in our sample.

We find that factors that hinder disclosure to children—age of the child, child not living in the same household as the mother, children having difficulties pertaining to adolescence are also the most important factors that hinder discussing the future with children.

One important assumption in the discourse on the impact of HIV/AIDS on children is that siblings in South Africa tend in any case to live in different households , and that this should not be seen as a unique negative impact of HIV/AIDS on children. The two mothers (one was the mother of a now sibling-headed household) who had discussed the future with their children, expressed a desire for siblings to live together after the death of their mothers. Powerful examples below of how mothers discuss the future with their children, and the benefits of such preparation (Box 5) clearly indicate the need to facilitate such discussions between parents and children:

> She feels that her children should stay together and should not be separated. Her house will be a family house. She does discuss issues such as preparation of a will and other legal issues. She feels that "When God calls you, you should be ready" (*Gugu, Mother of four children. The eldest is 21 years old and other children are below 16 years of age.*)

3.4 The Process of Planning for Children's Future Welfare and Security

For parents who face worsening illness and impending death, one of the most painful realizations is the eventual inability to care for their children and seeing them grow to maturity. Previous work in Western countries shows that children are at a greater risk of long-term negative outcomes if their parents fail to make custody arrangements before they die (Simoni et al. 2000). Children bereaved by sudden, unexpected parental loss demonstrate more negative outcomes than children who are prepared for such a loss, and the legal complications are greater (West et al. 1991; Rotheram-Borus et al. 1997). Future planning for the children can create a peace of mind for parents by assuring them that the children will be cared for according to the parents' wishes concerning their future.

There are, however, many barriers to this sort of planning. Parents may often be reluctant to initiate such planning because of a sense of guilt, denial of the seriousness of the illness, or fear that others may learn about the diagnosis (American Academy of Pediatrics Committee on Pediatric AIDS 1999). They may lack the information, skills, financial resources and tools to plan for their children's future. While there are previous studies on stresses that mothers face, comparatively little is known about how HIV-positive mothers/PCGs think about and plan the future of their children, or about the resources women draw upon for the security of their children once they pass away, especially in Africa (Marcenko and Samost 1999; Rotheram-Borus et al. 2004). Our study attempts to fill this gap in understanding in a South African context.

In this section, we report findings from our interviews with seventeen mothers/PCGs who are HIV-positive, one sibling head of a sibling-headed household and one grandmother of a grandmother-headed household.

From the interviews, we found that all of the mothers were thinking about the future and in the majority of cases were carrying out some level of planning for their children. Concurring with the findings of Marcenko and Samost's (1999) study of HIV positive mothers in Philadelphia, we found that plans of HIV-positive mothers in our study ranged from organizing future care giving arrangements to preparing wills for inheritance. Respondents also identified very specific barriers to their planning initiatives, and to the hopes they had for their children once they had passed. Discussions during this section of our interviews were imbued with sadness, tears, and in some cases fear.

Care giving Arrangements

The most important type of planning identified by the mothers interviewed was that of planning for the future care giving of children. As Bongi stated, *"Mothers will usually identify family members in advance who could care for their children and sometimes even speak with them about this. It is usually family members because they are the ones who will care for the children as their mother's did- raise them as their own."* Our research found that identification of family members as potential caregivers was a common trend amongst HIV-positive mothers (Box 6). Identified family members ranged from the respondents' mothers and siblings, to their older children who mothers hoped would be able to cope without external adult support once they had passed on.

Box 6 Going to Live with Your 'Other Mother'

Mafu, 36, is a mother of four and lives with her husband in Umzimkhulu. In 2003 she tested positive for HIV after the birth of her daughter. Recently she and her baby were diagnosed with TB and are currently being treated. The first person she disclosed to was her sister in law who has been incredibly supportive of her emotionally as well as through care giving and frequent visits. When she became very ill both of her sisters offered to take her baby to alleviate the burden on her, and the child is currently in the care of her sister who lives closer to her so that they can visit.

When she was especially sick she spoke to her sister about caring for her children when she passes away and her sister agreed. The three youngest children will go to live with her and she has even spoken to them about it. She has said that "there will come a time when you will go and live with your other mother." She says that "even when you ask the children who their *other* mother is, they know."

Mafu trusted both of her sisters to watch over her infant daughter and was in a position to ask either to take in her children when she passes away. This story attests to the strong ties between families, and especially women. Children are aware of their extended families as their most intimate support networks, to the point where children not only have one mother, but can claim to have multiple mother figures ready to watch over them.

Grandmothers were the most often identified persons for the role of future caregiver. The dynamic and essential roles played by grandmothers can be seen in a variety of ways. First, in the three cases where mothers were not sure what would happen to their children, the relationships with their mothers were extremely strained. This was very distressing to the mothers. They broke down into tears during their interviews.

> She has made no plans. She says that even if she fell very sick she would still look after her daughter. She doesn't think her mother would look after her daughter at all even if

> she passed away. She would probably take the child to the baby's father if she were extremely sick because she would not know what else to do (*Molatela, mother of a 2 year old who lives on her mother's homestead in Umzimkulu. Her mother lives in the city.*)

In many cases grandmothers are already playing significant roles in child-rearing (as discussed in the section on children's mobility) as well as in supporting their HIV-positive daughters emotionally and materially. Six of eighteen mothers indicated that their children would be living with their grandmothers, thus demonstrating the strong ties between children and their maternal grandmothers. Only one mother who is currently living with in-laws stated that the child would continue to live with her paternal grandmother once she had passed on. As one key informant working with orphans described, *"in most cases, before the parents pass away they send the children to the home they are going to be living in*" so that the transition is relatively painless for the child. Because traditional Xhosa culture has assigned a significant care giving role to grandmothers, this transition is generally seen to be less traumatic for children.

An excellent example of the active participation of elder women in sustaining the strength of family networks comes from our Paarl site. In this case we had the opportunity to interview not only the young HIV-positive woman, but also her mother in order to better understand how networks respond to the impact of HIV/AIDS at the household level. In this case the young mother had been abandoned by her husband, leaving her and her young daughter to fend for themselves. At this time, the respondent's mother had taken them in to live with her. When we asked the mother about future planning for her daughter, she described the following:

> She finds it difficult for herself to do this [planning] because she does not have the financial means to plan certain things. Right now, no one in her immediate family could look after her daughter. She has told them that should something happen to her today she thinks the best place for her daughter would be the orphanage. Her mother wouldn't really have the strength or capacity to do it and she doesn't know what would happen to her. She thinks that she would be best treated at an orphanage (*Pule, mother of two children*).

In terms of planning, the young woman described a last-resort reality whereby there would be no one left to care for the child, forcing her to live in an orphanage without any ties to her extended family. However, what is so interesting about this case is what we learned when we spoke with her mother, the 59-year old grandmother of the child. This grandmother had been a very supportive mother emotionally and was also acting as a caregiver to her granddaughter while her daughter served as a coordinator for the local TAC office. She told us that although it was very difficult for her at first, she says, *"when you discover your child is positive, you should treat them as you treated them before you found out."* In terms of the future well-being of the child, this grandmother had her own idea of what she was capable of and the role she would play:

> If anything happens to my daughter I would help and care for my granddaughter. If I was too old to do this then my other daughter would be the ideal person to care of her and would raise her (*Pumza, mother of an HIV-positive mother*).

This case attests to the fact that not only do mothers plan for their children, but in some cases the extended family may be doing so as well. Further, while some women may feel that children would be a burden on elderly grandmothers, grandmothers themselves may feel up to the challenge. There is more research required on how elderly women themselves interpret their roles in the era of HIV/AIDS, and how this can be bolstered as part of an effective response to the crisis of future care giving of children.

When grandmothers were not present, available or capable, sisters to the mothers were often the next choice. Five mothers indicated that their children would be living with aunts. Three mothers in our sample are already hosting maternal orphans who are their nephews or nieces, demonstrating how common this practice is. For example, 35-year old Nomaindia thinks that her sister would be the most appropriate person to take care of her two year old daughter. But, she says, "*I haven't yet spoken to her about it but will [do so] when the time comes*". The following examples display some of the thought processes of the women interviewed:

> She thinks that her sister will be the ideal person to look after her child. Her sister is 21 and already looks after her child. She loves him and knows that she would take good care of him. She has asked her already and her sister has agreed to look after him. However, she does this in a more general manner. For example, she will say, "one day, if anything were to happen to me…" She is planning though to disclose to her in June. Her sister does ask why she talks about death a lot but she hasn't yet told her. They have a very good relationship though so she is confident she will be supportive. (*Tumi, mother of one child*)

While the extended family continues to be the first line of defense for most mothers and their children in the era of HIV/AIDS, three mothers identified their eldest children as potential caregivers for their youngest in the future:

In another case from Paarl, Gugu, a mother of four stated that "*her children should stay together and should not be separated*". In this case the respondent felt that her children would be able to survive once she passed on because they would be protected and able to reside in what would be their family house. While there are some cases where children were deemed capable of looking after themselves and each other, this was only evident in Paarl where fewer households in general have remained intact. In most cases, mothers expressed a preference to have another adult take over the care giving responsibilities.

Apart from the three mothers who had poor relationships with their own mothers, all of the mothers in the sample trusted the identified future caregivers to care for their children. Significantly, none expressed fear of abuse, neglect or property grabbing. This has profound implications for the positive living of the mother as well as the future well-being of HIV/AIDS affected children.

Ziyekele's story is an illustration of this. Ziyekele, a widow and a mother of a two-year-old daughter, lives with her mother-in-law and sister-in-law on their homestead. Ziyekele is currently trying to access her husband's retrenchment funds. Is she gets this money, her daughter will inherit it. She says, *"if anything were to happen to me, my mother-in-law will take care of my daughter. I am* not *worried that my mother-in-law will try to access any of [the money]. I trust her.*"

Our research also demonstrates the incredibly strong ties that exist between women in South African extended family networks. Most of our respondents were confident that the future caregivers would do their best to provide for their children.

Planning for Inheritance and Will Preparation

Most of the mothers in our sample either rent or live with their parents/in-laws. Often they are not in a position to pass on assets to their children. However, one important thing to note is concept of 'family house' in South African Xhosa culture. For many Xhosa families, the deed of the house is in a family name, and not in the name of one specific person. In cases where some women were living with family, their death would not necessarily entail the necessity of formulating a will, because through tradition her children would be guaranteed the right to remain. However, in other cases, women formulated wills in order to guarantee the rights of their children to reside on the property and to ensure that the house remained in the family. This was the case for two of the households interviewed (Box 7).

Box 7 The *Family* house

For two women in Paarl, the question of inheritance and where their children would reside once they passed away was settled by the Xhosa concept of a *Family* house.

Vuyo, 40, is a mother of one child, but is also fostering five of her deceased sisters children. They are currently living in what was her parents' home. Her parents died 11 years ago and left it to her and her sisters as a family house. For many years she has lived in this house with her two sisters until they both passed away. In terms of the house and inheritance she says that the house is a *family* house and will always remain so. "The house belongs to everyone." She does plan on going through a process to make sure that the house remains in the family and she can leave it the children of the family. It was their grandparents house and they have a right to remain living there.

Gugu, 38, is a mother of four and lives with three of them in a house that she owns. When she passes away she would like the house to become a family house. She feels that her children should stay together and should not be separated [this is something that her son does not like to discuss]. Her house will be a *family* house. She has already prepared a will and has hired a lawyer to handle things. While she is not necessarily afraid that others in the family will try and 'grab' the property from her child, she is working now while she is healthy to ensure that they will always have a home.

Financial Planning

Overwhelmingly, the most commonly cited constraint on mothers' financial planning for the future was poverty. More than half of the mothers in our sample had not yet started to save for their children's financial future. The common occurrence of abandonment by husbands/fathers of children had exacerbated the vulnerability of these households and made saving impossible. Indeed, in only one family in our sample did the father of the children reside in the same household. However, in this case the father also described the constraints of poverty in his efforts to plan for his children's future.

Despite such poverty and the lack of stable incomes, several examples illustrate that mothers are engaging proactively, within their constrained economic circumstances, in providing financial security for their children. Mothers typically started saving whatever they could and often said "*although it is not a lot, it is something*." (Box 8)

Box 8 Working to guarantee future financial security for children

Tumi, 30 is a widowed mother of a four-year old son who currently lives with her mother and grandmother in the Eastern Cape. She resides in Mbekweni, a township near Paarl where she supports herself through the Disability Grant. She has matriculated and worked in the past for the municipality, but currently is volunteering for the local branch of the Treatment Action Campaign (TAC). She educates others, including her father about HIV/AIDS in order to alleviate stigma and pass on the information is learning.

While she thinks that many women do not plan, she has been planning in a variety of ways for her own child. Right now she is putting R50 per month into an account for him.

When her husband died she did not receive anything. There was struggle for assets and the property that she shared with her husband but after a period of time her mother told her not to bother anymore and to give up fighting. However, her in-laws have told her that they have set aside money for her child and that when he turns 21 they will pay for his Varsity. She has concerns though about whether or not this will materialize and would like to gain support on how to take legal action to make sure this is there for him.

Further, in two examples where the father of the children was alive, two mothers in our sample were seeking child maintenance support through legal channels. In both cases their efforts had been successful. Tuleka, mother of three says, *"[the father of her children] is actually paying her some money right now per month (R700 total) but has been trying to stop payments and so it is a constant struggle".*

Agency of mothers to provide for children, even in the most difficult circumstances, can be found in Ziyekele and Thandiswa's stories. Both of them are trying to work with the employers of their deceased family members to gain access to their savings.

For many of our respondents, government grants were the only stable sources of income, and were utilized directly to support the children of the households. In some cases, mothers made sure that their children would receive the CSG even after they passed away, making it easier for the subsequent caregivers to take care of the child.

> The twins' mother was sick for a long time and during that time she applied for the CSG even though she was weak at times. This has made it easy for grandmother to take care of her grandchildren (*Thandiswa, grandmother taking care of maternal orphans*).

Funerals are often expensive and can drain family resources. Membership in a burial society or having a funeral policy spares the family from resource drain. Thandiswa's experience with her daughters' planning illustrates the point. She states "*My daughters planned for their children. Both my daughters belonged to Burial Societies, thus it was easy for them when they passed away*".

While most mothers expressed the desire to either belong to a burial society or to buy a funeral policy, most could not afford to do so. Only six of nineteen mothers/primary caregivers in our sample either had a funeral policy or belonged to a burial society. Only one mother in our sample had directly included her child on her funeral policy.

4. Living as Orphans: Findings from KwaZulu-Natal Province

This section turns to the study of households after children have become orphaned, looking at where children go, who fosters them and why, and experiences and conditions of orphans within new household structures.

As emphasized throughout this paper, household mobility patterns over many decades in South Africa have left children living without biological parents, so that the 'adoption' of 'social orphans' is a long-established practice in the country. Madhavan (2004) elaborates on patterns of foster care before and after the onset of HIV/AIDS, and debates whether existing living arrangements are just a continuum (of previous patterns) or a new development responding to the pandemic. Fosterage has always been present in African families; however, fostering patterns have been exacerbated by the devastation of family structures from AIDS. Madhavan distinguishes between two basic patterns of fosterage: voluntary and crisis-led fostering. Voluntary fosterage pertains to arrangements between biological and foster caregivers to raise the child. Crisis-led fostering occurs in response to the death of a biological parent or the occurrence of a major shock or hardship, as is the case of the huge number of children orphaned by AIDS. While social parenting is not a new concept in South Africa, children orphaned by AIDS have often experienced (as section 3 shows) stress and trauma from prolonged caretaking for sick adults, living through premature death of biological parents, clustering of deaths in households, and prolonged and exacerbated periods of poverty. They may be dealing with stigma and discrimination. While crisis-led fostering more accurately describes the situation of children fostered to cope with impacts of HIV/AIDS, this process is articulated with historical patterns of voluntary fostering. The research findings which follow attempt to better understand these dynamics.

4.1 Who Fosters Orphans? Culture, Agreement, and Conflict in Household Selection

Brady (2003) notes the prevalence of the belief that, in the context of the AIDS pandemic, family structure is not coping with the care of orphans, but also points out that the existing literature does not adequately address the changes confronted by orphans and their families. Our findings suggest that in fact family structure does cope with the care of orphans—it is mutable enough to respond to crisis situations requiring care for children. The primary obstacles to the provision of adequate care of orphans are not sociological but economic.

All the orphans in our study are fostered in relatives' households, divided almost equally between households of grandparents and those of aunts and uncles.[10] None had migrated from other areas. Many informants made the point that in this society, the formal responsibility for

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[10] Madhavan's (2004) also found that there were two well-defined groups of people who become primary providers of the orphans when they are fostered by kin: the children's *grandmothers* and the children's *aunts.* She notes that both groups show willingness to take care of the children but also seem to have no choice, a point that is consistent with our observations. Hosegood (2003) found that in KwaZulu-Natal children's migration is closely related to their parents' migration and/or to the dissolution of the child's household. However, she also found, as we did, that children may join other households (those of relatives) in the homestead instead of migrating upon the dissolution of their parents' household.

caring for orphans falls upon the patrilateral relatives. One noted *"Mpiyakhe says that in the African culture the children of your brother become the responsibility of the living brothers when one passes away"* (Msimango). Other informants emphasized that such responsibility in fact lay with grandparents, and in this case did not distinguish between matrilateral and patrilateral grandparents: *"She said that as the grandparent, the child of your daughter/son is also your child in the African culture. If the mother dies or gets married to other male partner the grandmother has the responsibilities to take care of the children"* (Khubona). A key informant who worked for an organization that grows vegetables to supplement orphans' diets also stressed the particular importance of grandparents: *"Aunts and uncles are helping to live with orphans. But people who are really taking good care of orphans in the community are grandparents"* (KII Umlazi). Another key informant, working for an NGO dedicated to assisting foster families' grant applications, made the point that grandparents could at least rely upon the limited but regular income of their pensions (KII KwaMashu, Mrs. L). Box 9 describes the structure of the Mchunu family who took in two orphaned children of relatives. This story exemplifies a point discussed earlier: that in spite of Zulu kinship models which enjoin patrilateral responsibility for orphans, it is predominantly matrilateral kin who take care of orphans. This family presents a joint-care pattern: grandmother-aunt, who take care of two orphan children living in the household at the same time. It also demonstrates the dual concepts of adoption, official and cultural, discussed below.

Box 9 Family structure and 'adoption'

Granny Sisana is the head of the Mchunu family. She is 83 and receives the Old Age Pension grant. She had four children, of whom only one is a resident at the household; two migrated and one died. One of her grandchildren, Nandi, 35, lives on the same property but in a separate structure. She has two children and receives a Child Support Grant (CSG) for her youngest daughter Bongi, 6. Nandi and Sisana are taking care of Khosi, 11 and Samkelo 13; both are orphans and closely related by blood. The Mchunu family has experienced a number of losses, with several family members having died, including the mothers of Samkelo and Khosi. Both mothers were Sisana's granddaughters, hence, the children are related to Nandi through matrilineal ties.

Nandi formally adopted the children. She has registered them in court and received a legal document certifying that she is their foster parent. Having this certificate is a step forward when applying for the Foster Care Grant (FCG). Another family member made the following comment about the Mchunu's and Nandi's decision to adopt the children: *"She (Nandi) says that the children were registered at the court and that she has gotten their certificates. She thinks that this is important that the government recognizes her as the primary caregiver of the children and that she is acting as their mother*". Nandi also said that she adopted the children in order to be able to apply for the FCG, which would allow her to offer them a better life. However, she explained that otherwise she did not see the need to adopt the children in a formal way, the children were accepted as part of the family anyway, when their biological mothers died. Nandi said that she was motivated to take care of the children because she is their aunt and nobody else would do it besides her and Sisana. (Mchunu)

Divergence from an idealized protocol is by no means uncommon even in kin-based societies, and in this sample it would appear that some bias towards matrilocal fostering can be explained by the fact that sick and dying mothers are often cared for by their families, leading to a situation in which the status quo is maintained and their children remain with these families after their parent(s') deaths in spite of such protocol. Also supporting the status quo argument is the fact that most informants report that the orphans were, prior to the death of their biological parent(s), already living in the households in which the interviews took place. A different interpretation of the situation centers on the wives of patrilateral uncles, who do not necessarily want to accept the children of their husbands' siblings: *"Brothers complain about culture, that the children must be with the relatives of their father. Some said their wives will not like the idea of having the children move in with them"* (Mbatha).

Conflicts over selection of foster households did occur in some cases in our study, but these were relatively rare. Where they occurred they tended to arise from the tension between the patrilocal residence ideal and the matrilocal status quo (where the child already resided). However, some conflicts are rooted in poverty, where conflicts over resources supersede notions of cultural obligation. In the case of the Mchunu family (discussed above) a conflict arose when a matrilateral daughter-in-law (i.e., sister-in-law of deceased) claimed custody against the maternal grandmother (who had received socially sanctioned custody when this was announced at the funeral of her daughter), allegedly in order to acquire her late sister's furniture: her claim would be strengthened by fostering the children. Conflicts over fostering can work in two directions, creating pressure to foster the orphan (Box 10) or against fostering (Box 11).

Box 10 Property and Adoption Conflict (pull)

She says that Nonhla, Vusi's partner did not want Nonhlanhla to take the children. She thinks that she had other intentions in mind. She wanted to satisfy her needs. She thinks that she wanted to take all the furniture which was owned by Mary. She says that Mary had the beautiful furniture in her mother's house. Nonhlanhla says that Nonhla took all the furniture that was in the house even though she knew that the children would not stay with her. Nonhlanhla believes that she was supposed to take the furniture as the children are staying with her. She says that she decided to avoid the arguments in the family and not to take the furniture. She says that the problem was not solved. Nonhlanhla decided to take the children and shut her mouth. She says that it was very difficult after the funeral of Mary. She says that there was a conflict and there was no communication within the family members. They did not talk to each other, with Nonhla. She says that things have changed now. They decided to forgive each other. She says even though they don't have a good relationship with her but they talk to each other. (Mchunu)

Box 11 Property and Adoption Conflict (push)

In January, 2004, Nhlanhla visited Mpiyakhe's household. According to Bongi, Nhlanhla did not go home in the afternoon and when Sibongile wanted to find out from her why she was not going home, Nhlanhla burst into tears. Sibongile comforted her and, in the most gentle manner, again tried to find out whether there was a problem. She whispered to Bongi's mother Sibongile that she had a problem at home and she no longer wanted to go home. She told Sibongile that her stepmother was ill-treating her and refusing to give her food...It transpired that there was serious conflict between Nhlanhla's father Fikile and his wife regarding Nhlanhla being part of the household. The stepmother Boniswa preferred to have her own biological child only as Nhlanhla's presence was threatening her ownership of the family property: in the event of her husband passing away, Nhlanhla could prove to be an obstacle in the way of Boniswa being able to secure the property as her own. Fikile was scared of Boniswa. He loved his child very much, but was powerless in stamping his authority. (Kuzwayo)

Concepts of 'Adoption' and Duty: Official and Cultural

Households in our study articulate and negotiate two overlapping but not necessarily congruent models of 'adoption'. The first of these, which can be labeled 'bureaucratic,' 'official' or 'legal,' is a procedure carried out in a court of law, in which the foster parent is registered in the eyes of the State as the official caregiver of the child. Although South Africa has an official procedure formally called "adoption" and a permanent arrangement, in this discussion we are referring to the legal procedure of becoming an official "foster parent." Though this status is not officially recognized as permanent, in the case of orphans it is rarely a temporary arrangement. We use the term "adoption" here interchangeably with "fostering" to refer to the long-term taking in of a child by a caregiver—our fieldworkers selected a Zulu word to represent this, which they translated into English as "adoption."[11]

The second notion of 'adoption,' which is better termed 'cultural' or 'customary,' refers to the socially accepted assumption of childcare duties by an appropriate household. It is important to understand certain contrasts: while official adoption is regarded as a *process*—a sequence of events involving documentation, many interactions with officials, and usually significant travel expenses and long waits, cultural adoption is a *given*. In other words, customary adoption among the study households is a stage in the life cycle; it is not a new concept, although it is certainly one where the increasingly prevalence is directly related to increasing rates of HIV/AIDS. Assuming the duties of caregiver for the child of a deceased relative is a cultural imperative, where there are living consanguineous kin to do so. According to one interview in the KwaDunuse cluster, *"The Mbongeni did not know the 'adopt' word, for them it was a natural demand from the ancestors to support the child and being their son's child, they had the responsibility to take in the child"* (Mbongeni). Another informant said *"...its normal in African people that when the mother dies, the grandparents take care of the grandchildren...Florence says that she didn't have a choice but [to] care for the child, if she doesn't then who will take care of Elias? Nobody else! It was her responsibility"* (Bongani). A key informant from the KwaDunuse cluster explained that: *"The notion of orphan does [not] exist in the minds of the African people. They do not see an orphan, but another child who happens to be without parents and that is a natural thing."* (KII Mrs. B). As seen also in the Eastern and Western Cape case studies, the fostering relatives were sometimes selected by dying parents.

Motivations for Fostering

If customary adoption is enjoined by social norms, then when and why do foster parents choose to take the further step of 'legalizing' the relationship? Given that an orphan has been adopted according to customary rules (in our study this preceded legal fostering), then either the foster parent(s) proceed to legally foster the orphan or they do not. The most frequently cited reason for legalizing the relationship is to permit access to government grants, specifically the Foster Care Grant that requires this formalization: *"...she has adopted the children now in 2004. She says that she is registered at the court and she has got the certificate. She thinks that the important thing to adopt the child is for the government to know that you are the primary care giver of the*

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[11] Fieldnotes were translated directly into English by fieldworkers, who regularly used the English word "adoption" to refer to both customary and legal processes.

children, you are responsible for them, and you act as their mother. This gives them an opportunity to apply for the Foster Care Grant" (Mchunu). One key informant pointed out that occasionally households elect to foster children mainly for the sake of obtaining a grant: *"In some cases, the new people who have to live with the children only need the children so as to apply for the orphan foster grant, not because they have the interest of the child at heart"* (KII Mrs. B). On the one hand, if the grant serves as an incentive to take in children who need a family, this is not necessarily problematic. On the other hand, in such situations it is possible that the child may not receive the benefits of the grant to the extent intended.

A second reason for legal adoption, less-mentioned but still important, results from customary adoption norms enjoining patrilateral adoption: if customary adoption norms seem likely to result in a claim on behalf of patrilateral relatives for the custody of an orphan who has been taken in by the household of matrilateral relatives, then legal adoption can help to protect the matrilineal caretakers*: "She said she adopted her because she wanted to have the legal custody of her. She was afraid of maybe the father's family will show up after hearing that her sister is dead and claim Nolwazi"* (Nkosi).

There are two main reasons for not legalizing a customary adoption. The most prevalent of these is a lack of knowledge of the process, coupled with a strong belief in customary adoption; thus, a customary foster household will not proceed to legally ratify the adoption because it believes that the child is already 'sufficiently' adopted by the family, and/or because they do not know anything about the legal procedures: In two households in the KwaBrush cluster:

> *"Mandla and Thandi say that they have not adopted these children in 'legal terms'. They say that they didn't know about the legal alternative to adopt the children. Mandla says that there is no such thing known as 'legal adoption' in the Zulu culture. They know that the living family members, especially the brothers of the deceased are liable to take care of the wife and the children of the deceased. This is the only adoption they know. They never heard about legal adoption or doing the court procedures to show that they are primary caregivers of the orphaned children. Mandla says that they didn't know the significance of doing that court procedure" (Msimango).*

> *"Phumalele asked the question of why she has had to adopt her own grandchildren, her own blood—she does not understand this adoption thing I was talking about. She said she only knows one thing—that her daughter had died so she is the one who is responsible for them" (Ndlovu).*

Another reason for not legalizing the fostering arrangement relates to the legal requirements. There are a range of problems encountered in attempting to do this, which are discussed in section 5.2.

4.2 *"At no stage should Nhlanhla be regarded as an orphan"*: Researching Discrimination and Stigma

Discrimination and stigma associated with orphanhood, and more specifically with being an AIDS orphan, are relevant both in emotional/psychosocial terms and in terms of physical care and nurturing of children. Brady (2003) urges the consideration of how stigma is constructed and ways in which it is affecting other dynamics associated with AIDS, as well as how it relates to poverty, orphanhood, and the ways people cope with AIDS; this call is echoed by Madhavan (2004), who additionally advocates work on the effects of stigma upon social bonds in communities affected by AIDS. Brady also suggests that stigma associated with AIDS might discourage people from applying for available grants and services for fear of exposing their situation to the public gaze. We should note that in our case studies we did not find stigma to be a significant obstacle to applying for grants: while many households in our study failed to access grants and services, this had—with two interesting exceptions—other explanations related to lack of knowledge of application procedures, inability to obtain the correct documentation, or concerns about lengthy delays and ultimately being unsuccessful (see section 5.2).

Nevertheless, the findings in our study also reveal that stigma and discrimination do exist at both the household and the community levels, and where present this can manifest itself in different ways, ranging from differential treatment within the household, to ill-treatment in schools and communities—though in our case studies we found less discrimination than does the literature on orphans in Africa. Significant evidence of discrimination—particularly with regard to education—was found by Case et al. (2004) in a study of 10 countries in sub-Saharan Africa, and by Case and Ardington (2004) in South Africa (see below for further discussion of these findings). Madhavan (2004) states that there is evidence that foster children are at greater risk of death than biological children, as a result of deprivation, related to food, work and other forms of discrimination. According to Madhavan, clinical studies found that foster children tend to fall sick more often. However, she also notes that in poor households, foster children undergo the same fate as do other biological children and it would be a mistake to isolate fosterage as a cause for child mortality. There is a large variety of fosterage arrangements and the difference in treatment reported is exacerbated by gender and location (rural/urban). Madhavan suggests that there are two important elements to take into account when measuring the well-being of foster children: 1) Intra-household resource allocation amongst foster families, and 2) the access and movement of resources between biological and foster families (land, livestock, and other assets). In the context of our study, the second element is less relevant because there is little movement of resources between biological and foster families; the biological families, have just faced lengthy illnesses and loss of breadwinners, coupled with a chronic state of poverty, means that there are few resources to be negotiated.

Discrimination and stigma are difficult topics to research, because asking about them elicits feelings of pride, defensiveness, and fear among informants (see Box 12). This may in part account for the divergent results that we received in responses from household interviews with those of key informants. Household interviews were carried out in households where orphans are fostered, and with people who are reflecting largely on their own treatment of the children in their households. It would be unlikely to find cases of self-reported discrimination, although in one case study household one member described mistreatment by others: *"Florence says that Elias is not treated the same like the other children in the Bongani household. She says that when she is not at home, the other children beat Elias and the adults don't stop them. She says that they don't give Elias food when they dish food for other children. They chase him away and tell him to go to his mother's side"* (Bongani). The story in the "push" box above also describes a condition of discrimination within another household. In the other case study households, however, informants were at great pains to emphasize that the orphans in their households were treated with the same love and care as the non-orphans of the household, even when this involved stretching resources to make ends meet for everybody: *"They say that there have not been a lot of changes in the household except that there has been more washing to do and there is need to cook more food. They say that they don't regard this as change but as an understanding that children get hungry all the time. Even if they don't have enough food to cook they don't relate that to the orphans because they treat them as their own children. It doesn't make any difference"* (Mchunu). It is interesting to note that in the Khuzwayo household featured in the box below, "Conducting research on orphans," the male head of household protested our fieldworker asking about discrimination and changes in the household since the arrival of the orphan, insisting that the orphan was treated the same as other children in the household. However, this is the same household in the "Push" box above, where discrimination was evident.

Box 12 Conducting research on orphans

Bongi emphasized that her father did not want to regard Nhlanhla as an unnecessary appendage and warned the fieldworker that he would be very cross if he were to be asked the question as to the financial circumstances since Nhlanhla became a member of the household. Bongi said her father called them to a meeting to inform them about Nhlanhla being part of the family and emphasized that at no stage should Nhlanhla be regarded as an orphan or as somebody who should get less attention, compared to the other members of the household. (Khuzwayo)

Although among our household case studies we had a stronger set of responses and observations indicating that orphans are treated the same as biological children than those indicating discrimination, we can not draw conclusions about relative prevalence of these conditions, and believe that survey data is better for establishing this. However, our case studies do indicate that both sets of conditions exist, and provide some insights into the cultural, social and economic drivers of these different conditions. Key informants were more ready to discuss discrimination and stigma. While some claimed that orphans experience neither discriminatory treatment nor stigma in the community, home or school, others stressed that such problems do in fact exist. In an example of the former tendency, the teacher from the KwaBrush cluster said that:

> *There is no stigma associated with being an orphan in the community. The people know that the children are orphans. The families don't talk openly about their status of being orphans...the children realize their orphan status when they have grown up...they are not treated differently compared to other children in their household. The members of the community are always willing to offer assistance to the orphans and their families but it's hard. They are also poor and they can't even support themselves sometimes."* (KII,, Mrs. H.)

Other key informants portray a more negative environment, citing instances of both discrimination and stigma. One key informant made the point that orphans are discriminated against at school because they are visibly poorer than other pupils: *"Orphans will become a laughing stock to other children because of one uniform that happens to have patches so they drop off school"* (KII Umlazi). This example suggests that even where foster families endeavor to provide equally for the child, insufficient income (that may have been exacerbated by taking in new household members) is what causes the stigma. Though this could be compounded by other children's knowledge of the child's orphan status, we did not find specific evidence of this.

A key informant from another cluster mentioned a case in which an orphan was being 'employed' as a cowherd by the foster parents, and she was "*called by the neighbours who were complaining about the ill-treatment of the child: the child was being sent to herd the livestock even when it was raining. The child was being paid a nominal fee of R50 per month and the fees and food provided by the foster HH., but the ill-treatment could not be condoned"* (KII Mrs. B).

A school principal in the same cluster, with particular knowledge of the situation within schools, described some of the effects of poverty and stress on school performance:

> *Some orphans who are having problems would indicate this through their inability to absorb what they are being taught, they fall asleep too often in class, they isolate themselves from the other children. When pressed for reasons as to why they are unable to cope, some of them would simply cry and refuse to say what the reason is. Others, however, would just be brave and tell the teacher that they have not eaten for two days and have been surviving on water and they lose the will to study."* (KII, Mr. G.)

These stories of problems at home and at school provide a glimpse into the lives of children whose conditions of disadvantage, though only a few appearing in the qualitative study, show up in larger numbers in surveys. Using extensive survey data across a number of African countries, Case et al. (2004) and by Case and Ardington (2004) find that orphanhood has serious implications for school enrollment and attainment, particularly for maternal orphans and double orphans. Case and Ardington contend that 'mothers are considered the gatekeepers for their children's education and when they are gone no other caregiver insures that they (orphans) get to school and/or school uniforms and fees are paid for.' Case et al. found that 'mothers tend to invest more in their children's wellbeing and health than stepmothers do'.

Using simple two-way tables constructed from a—still relatively small—sample of 207 'fostering' households in the KIDS 3 data (out of 1428 total surveyed households) and 333 'fostered orphans,' we did not find significant differences in these indicators between 'orphans' and 'non-orphans'[12] looking at absenteeism (Figure 4.1), grades completed by age (Table 4.1), grade repetition (Table 4.2) and math test scores (Table 4.3).

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[12] In the KIDS 3 data, a child is considered to be a 'fostered orphan' if: i) at least one parent is deceased; ii) s/he is a new households member in 2004 (not captured in 1998); and iii) s/he is between 6 and 20 years of age (to exlude children born in the 1998 households after 1998). Note that condition (i) thus includes three types of orphans: maternal, paternal, and double; and condition iii results in an underestimation of the actual number of orphans in the surveyed households, since many are likely to be less than 6 years old. A 'fostering household' is one having at least one child satisfying criteria i) to iii).

Figure 4.1: Days of missed school in the last month

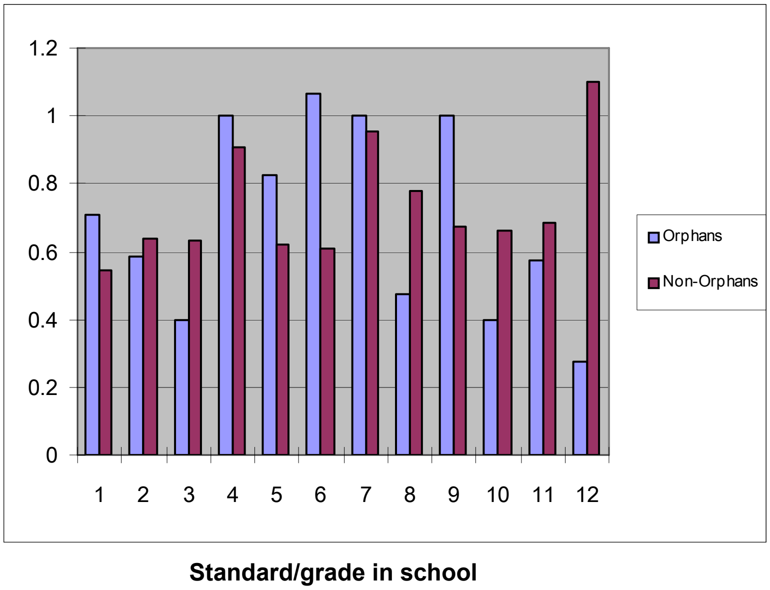

Table 4.1: Average years of schooling (grade completed)

Age	Foster/orphans	Non-orphans
7	0.6	0.7
8	1.5	0.9
9	2.4	1.6
10	3.4	2.4
11	3.6	4.2
12	5.3	5.1
13	5.3	6.1
14	6.7	6.9
15	7.4	7.6
16	8.6	8.5
17	8.6	9.1
18	9.1	9.7

Table 4.2: Schooling years repeated (average)

	Foster/orphans	Non-orphans
Primary	0.59	0.65
Rural	0.62	0.68
Urban	0.41	0.49
Secondary	0.83	0.87
Rural	0.92	0.93
Urban	0.52	0.72

Table 4.3: Correct answers (percent)

Summation	Foster/orphans	Non-orphans
Age		
7	0.67	0.72
8	0.82	0.88
9	0.96	0.92
Subtract		
7	0.47	0.54
8	0.65	0.75
9	0.79	0.81
Product		
7	0.27	0.28
8	0.29	0.47
9	0.58	0.65
Division		
7	0.667[a]	0.069[b]
8	0.12	0.21
9	0.42	0.37

[a] This is unusually high. Standard error is large due to the small sample (15).
[b] 14 out of 203.

Note that this data includes maternal, paternal and double-orphans, and thus a substantial inclusion of paternal orphans might help to explain the difference in our data from that of Case and Ardington. For grade repetition we found slightly higher averages for non-orphans than for orphans, for both primary and secondary school children and in urban and rural areas (see Table 4.2). Table 4.4 indicates that in urban areas the average school fee paid (at an individual level) for non-orphans is substantially higher than for orphans (more than double for primary school children and about 50 percent more for secondary school). However, in rural clusters the average school fee paid is about the same for both groups (slightly higher for orphans but not significantly) in primary school, and higher for orphans in secondary school: R 175 vs. 145. We should also consider the possibility that better-off households are more able to foster orphans children and it is this difference that is reflected in this indicator.[13] The data on grades completed shows a trend toward better performance of orphans than non-orphans at younger ages (8-10 years) but the opposite trend among older orphans (13-18 years old). Also, measurements of school performance in terms of correct answers on math questions show some significant differences for 8 year-olds, with non-orphans performing better than orphans, though the difference is marginal for 7 and 9 year olds. It is difficult to imagine the basis for differences with respect to these age groups, and it is thus more likely that the data do not reveal significant differences. It is also possible that in a regression analysis the differences would disappear altogether, or they might become more significant. Using the KIDS 2004 data in a regression framework and looking at the period in which the child became orphaned, Yamauchi and Buthelezi (2005) found that orphanhood appears to have long-term effects on schooling continuation and labour supply decisions, but only a limited impact in the short run.

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[13] This hypothesis was suggested by Futoshi Yamauchi, who also prepared the quantitative tables that revealed these findings.

Table 4.4: School fees for orphans and non-orphans

	Orphans	Non-orphans
Primary school	71	84
Rural	68	59
Urban	83	182
Secondary school	157	177
Rural	145	117
Urban	204	355

One possible reason why our case study households found less evidence of discrimination with respect to schooling than one might expect given the findings of other studies may lie in one of the points raised by Case et al. (2004): 'the lower enrollment of orphans is explained to a greater extent by their living arrangements with non-close kin or non-kin caregivers.' As noted earlier, all of the orphans in our study were fostered by close kin. As one key informant emphasized: *"...when the orphans are taken in by the relatives, the environment becomes for the child's future well-being. There is natural closeness, unlike in the case of the outsiders where the child has to adapt to the new surroundings...but in the case where the children stay with non-relatives, the situation is not good. The children may tend to be molested and not given enough food like the other children."* (KII Mrs. B).

Association with HIV/AIDS brings its own kind of stigma. Some informants stressed that this was something people preferred not to even refer to by name, electing to use well-understood euphemisms such as 'sickness.' However, one key informant observed that as the infection rate had risen, the moral stigma attached to association with HIV/AIDS had reduced, as it became a more quotidian feature of community life:

> *...when the rate of the infection was low, people tended to isolate those of the household whose parents died of the infection. They tended to associate such illness with low morals in that particular household and the children of that household would be isolated by the community members, very few would want to be seen in their company. However, as the rate of the infection soars, the community members are now beginning to be aware of the fact that this is...not easy to run away from. It has become rooted in the communities everywhere and it is not about the low morals only.* (KII, Mrs. B.)

This concurs with Brady's (2003) contention that stigma and ostracism result from a lack of knowledge of how to deal with HIV/AIDS: as the disease has become a more familiar presence in the community, people tend to understand it better and are less inclined to treat its victims with discrimination.

4.3 Child-Headed Households

Child-headed households (CHHs) are not a commonly-found household structure in KwaZulu-Natal. In a study of 11,000 households in the Hlabisa District in KwaZulu-Natal, no child-headed households were identified, except as a temporary arrangement (Lund 2003). Although we did not find any such households among the KIDS survey households in our six study communities to include in our case studies, key informants did speak of them, describing a qualitatively severe social problem insofar as it involves the most exposed and at-risk subset of an already vulnerable group (see Box 13). As Brady (2003) argues, HIV/AIDS is complex and entails economic, social and health issues that impact children in multiple ways: children affected by HIV/AIDS may experience multiple layers of disadvantages in their households, schools and communities. Orphans of child-headed households are especially exposed to such disadvantages. They are, in this sense, 'triple orphans,' lacking related or non-related fostering parents.

Box 13 A Cycle of Risk...

There were households that were run by the children and this was exposing the children to rapes and unnecessary pregnancies because they needed to survive. Most of these children survive by asking for food from neighbours or simply falling in love in exchange of money to buy food. Others do manual work for the neighbours, such as tilling their fields or being sent on errands and helping to repair fowl runs and fetching water for the neighbours...the situation was forcing the children into unsafe sex in order to survive and [the informant added that as parents] it was not enough to simply say they must keep out of sexual activities because they needed to buy food. Others were jumping into excessive alcoholic drinking and, consequently failing to attend school. (KII Mr. D)

The typical pattern appears to be one in which, after the death or disappearance of the parents, the eldest sibling ends up running the household and looking after his or her younger siblings. Such children face a gamut of risks and social problems, many of which are also related to the coping strategies to which they turn in order to obtain food and money. Coping strategies reported include begging, casual paid employment, crime, strategic pregnancy to access the Child Support Grant and early marriage. As one informant pointed out: *"The girls find themselves getting married in traditional ways at an early stage so that they can get support from their partners who are working in the mines. They are prepared to become the second or the third wives in order to get support. Other teenagers become pregnant with the hope to apply for the Child Support Grant to support themselves"* (KII Teacher Mrs. H).

Some Risks and Problems Facing CHHs

- Food: This is widely cited among key informants as a pervasive problem for members of CHHs. Obviously, lack of proper energy and nutritional requirements has indirect effects.

- School: Children from CHHs lack money to pay for fees, books, materials and uniforms; the lack of these necessities is a problem both in a practical sense and in terms of stigma—as noted earlier one key informant said that such children can be ridiculed by other children because they do not have these items. Older children miss school because they must seek paid employment. Some children turn to alcohol in their distress, with further detrimental effects upon their education. In the preceding section we argued that orphans' educational outcomes are closely related to the kin-status of their caregivers. Presumably the situation is considerably worse in the absence of any formal adult caregiver.

- Health: Alcohol and drugs are serious problems; in addition to this, as noted in the text box above, members of CHHs are at greater risk of contracting sexually-transmitted diseases from economic coping strategies involving sex.

- Violence and Crime: Also cited in key informant interviews is the tendency to drift into theft and criminal activities in order to survive.

- Lack of a Parent Figure: Informants cite the lack of an adult parent figure as a cause of discipline problems: younger children are said to lack respect for their older siblings; older children are said to create further problems by bringing their boyfriends into the home.

- Teenage Pregnancy: according to at least one key informant, girls from CHHs sometimes choose to become pregnant so that they can access the Child Support Grant.

Services Needed for CHHs

Informants cite a general lack of specialized services set up to help CHHs. In one community, children from these households used to receive help from the orphanage and have access to a soup kitchen, but this has now been withdrawn for lack of funds. In some cases, CHHs are assisted by friends and neighbors, and some schools have been willing to temporarily freeze fee payments, but these are not systematic or long-term solutions. Key informants suggest that dedicated community care workers should be charged with the task of making special checks on CHHs, and that adults should become involved in overseeing these households.

5. Informal and Formal Support for Orphans

5.1 Informal Support and Formal Interventions for Orphans in Africa

Richter et al. (2004) argue that in order to fully understand the effects of HIV/AIDS, the epidemic must be considered as a broad development concern and not only in epidemiological terms. Because HIV/AIDS in South Africa is not only a public health issue, but also deeply entwined with poverty and exclusion, interventions aimed at supporting orphans and fostering households are generally best if designed as a broader program to address the needs of all vulnerable children or poor household in a given community, to avoid stigma and inequities. .

Subbarao (2002) provides an extensive analysis of the issues facing orphans and their implications for interventions. The potential short-term implications for a child who becomes an orphan include: trauma, malnourishment, displacement, a high rate of school dropouts (especially among maternal and double orphans), increased work burden or child labor (paid or unpaid), high mortality and morbidity rates, stigma and discrimination. In terms of long-term implications, orphaned children are vulnerable to the loss of their inheritance, loss of land and other assets, the continuous and sometimes sharp decline in health and exploitation. There are also implications for their communities that include weakening of social capital, loss of work capacity and income, depletion of savings, the irreparable loss of knowledge transmitted from parents to children, and the increased burden (care giving, land, labor, etc.) on other households and community members. The cost of caring for orphans is high for households. It is estimated that it reduces the rate of household investment by up to one fourth, jeopardizing the household's ability to cope with other possible shocks (crime, civil unrest, draught, etc.).

In response to the enormous scale of the orphans crisis in Sub-Saharan Africa, and the accepted knowledge that the worst is still to come, countries in the region have launched a variety of strategies and interventions aimed at supporting these children, the households caring for them, and their communities. The interventions, informal or formal, have focused on a range of specific needs such as the supply of food, care, access to health and education, placement, and shelter, and others. In reviewing types of interventions that support orphans, Subbarao and Coury (2004) consider the range of potential circumstances that orphans may face. They conclude that there is a need for 1) immediate attention to the growing number of OVCs; 2) targeting those vulnerable children in a non-stigmatizing way; and 3) inter-agency coordination of efforts to avoid duplication of efforts and foster exchange of vital information to facilitate ways to scale up proven successful interventions. Richter et al. (2004) also call for a rigorous assessment of these programs and interventions, in order to scale up the more successful ones. Finding reliable interventions to channel internal or external funds (governmental, non-governmental and aid funds) to households and communities in need is a huge challenge. Some of the harshest criticisms of current approaches relate to targeting, consistency, low resources devoted to the problem and small scale. Scaling up requires government capacity to bear the cost, organizational capabilities at the community level, and replicability of the intervention. To date, there has been little consensus or reliable monitoring and evaluation data on programs that support OVCs (Subbarao and Coury 2004).

A wide range of initiatives and projects to support OVCs are found across sub-Saharan Africa. Studies (Subbarao 2002; Subbarao and Coury 2004) that look at forms of support in Burundi, Rwanda, Guinea, Malawi, Botswana, Uganda, Zambia, Ethiopia, and Zimbabwe have turned up the following:

- Cash—gifts or loans
- Housing/Orphanages
- Drop-in-Centers/after school centers
- Food parcels
- Clothing/school uniforms
- Counseling/psychological support
- Legal advice
- Day care
- School fees and supplies (fees waived)
- Healthcare and water supply
- Labor sharing projects
- Skills training/technical and vocational training
- House repairs
- Income generating projects
- Photo tracing program for young children's reunification
- Education vouchers

The number of programs to assist OVCs, their households and communities has been growing at a steady pace, however, only a handful of them have been evaluated. There is a high demand for more in-depth research, monitoring and evaluation of on going efforts and innovative programs (Richter et al. 2002).

5.2 Support for Orphans in South Africa: The Child Support Grant and the Foster Care Grant

In questioning our study households about assistance from government or NGOs for the support of orphans, we found little presence of the above forms of support. Despite our conceiving a wide range of possible formal and informal interventions that might be available, we got little response (those that we found are reported in section 6). Instead, the one form of support cited repeatedly was cash grants—the Child Support Grant (CSG) and the Foster Care Grant (FCG). The Child Support Grant (CSG), managed by the Department of Social Development, is provided for poor children under the age of 11. The age eligibility has changed over time from 7 to 9 years, and most recently to 11 years of age. Previsions are currently in place for another extension of the grant to children up to 14 years of age, and there is currently pressure to extend the CSG age eligibility to all needy children up to 18 years of age. This grant is intended as a poverty alleviation mechanism and any primary caregiver of a child—who qualifies in terms of an income-based mean test—is eligible. Caregivers of children who have been orphaned and fit the criteria can apply for the CSG. Although documentation is required to establish the applicant as the primary care giver (PCG), there are no prerequisites such as court orders or referrals from social workers (as there are for the FCG) in order to receive the CSG. In April 2003, the government of South Africa set the CSG in an amount of R160/month (Government Notice, 461, 31) and raised it to R170/month in 2004.[14]

The KIDS 3 data (see Table 5.1) show that about the same number of households applied for the CSG across fostering and non-fostering households, and about the same number are receiving it (about 30 percent receiving in both cases). However, it is interesting to note that in fostering households, the reason for being refused the CSG because the applicant was not the primary care giver (either because s/he was not the PCG or could not establish that s/he was) was much higher (23 percent) than for non-fostering households (4.4 percent). The main reason for not applying for the CSG for fostering households—that they do not have the required documentation—is 36 percent, vs. 26 percent for non-fostering households, implying that households who take in orphans are often not receiving birth and death certificates when the children comes to live with them. Our research confirmed that the CSG is the most important—and usually the only—source of support for orphans that the fostering household receives. As will be seen later, in practice it is relied upon far more than the FCG.

Table 5.1: Percent of KIDS 3 survey households that applied for and receive grants

	Fostering households	Non-fostering households
Applied for CSG	30.66	28.6
Receives CSG	30.43	31.2
Receives FCG	1.9	1.0

The FCG is targeted toward children 'in need of care'—who are being fostered regardless of whether their biological parents are alive—but orphans fall into this eligibility category. The FCG is at the center of social assistance policy with respect to children affected by HIV/AIDS. The National Integrated Plan for Children Infected and Affected by HIV/AIDS (developed by the Departments of Health, Social Development and Education in 2000) proposes several important interventions focused on the HIV/AIDS crisis, but does not have plans for orphans (Gow and Desmond 2002). The national Minister of Social development, in a 2002 address to the national Department of Education's HIV/AIDS conference, said that "The Department of Social Development is encouraging relatives to take care of orphaned children under the foster care package," and reaffirmed this in October 2004 in a DSD document stating that one of the Department's priorities was the "intensification of … registration of orphans for the Foster Care Grant" (Department of Social Development 2004). Draft children's legislation has also proposed new cash grants, some of which target orphans. (Meintjes et.al. 2003).

Two pieces of legislation govern access to the FCG.[15] Where children have no parent or guardian, or are living under abusive conditions, courts can place children in the custody of 'foster parents,' under the legal supervision of social workers. The foster parent can then apply (under the Social Assistance Act) for a Foster Care Grant, a cash grant of R530 per month per fostered child,[16] up to the maximum age of 18 years old.[17] Placements are made for a maximum

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[14] A third child-focused grant, the Care Dependency Grant, is available for children classified as requiring permanent home-care due to severe disability. This is not particularly relevant as a source of support for orphans.

[15] These are the Child Care Act no. 74 of 1983 and the Social Assistance Act no. 59 of 1992.

[16] This is the value of grant as from April 2004. It is possible that the amount will increase in April 2005.

two-year period, with monitoring by social workers and the option of renewal. As originally conceived, the FCG was intended as a temporary measure, where children were to be returned to their biological parents where possible.

Access to the Foster Care Grant in Practice

In the KIDS 3 data set, of 207 households classified as foster households, only 1.9 percent reported receiving the FCG (in non-fostering households this number was reported at 1 percent). Among our 18 case study households, three had the FCG grant, and another one household was in the process of applying. Since it is not possible that our case studies happened to capture the exact households that reported receiving the FCG in the KIDS 3 survey, it is almost certain that there was underreporting in the survey. Nevertheless, it is clear that the number of recipients is very low.

Several of the case study households had applied for the FCG but had trouble doing so. For those who do succeed, it is a welcome success for financial and other reasons: one registered foster care parent expressed pride in the government's recognition of her parental status: *"She was very proud when she answered [that] she is the legal parent of the four boys. She went to court and promised that she would take care of the children"* (Mbatha). This court process appears to have become associated with the term "adoption." Another respondent said that she "had no choice to but to adopt the child through the court procedures."

Of the households in our case studies, only one had not heard of the Foster Care Grant. Most respondents knew most of the following things: that the grant is from the government, from the welfare department, that it is for the support of orphaned children whose parents have either died or abandoned them; or for those who do not get support from their "existing parents." Some are aware of the requirements for establishing a primary care giver as the registered 'parent,' but only four households had done so.

Sources of information about the foster care grant came from community health workers, social workers and others from the social welfare office, word of mouth at the pay point (CSG or pensions), friends and others in 'the community,' and the radio. In one household, the community health worker visited households to tell them about the grants.

A number of reasons emerged for why there has been such little uptake of the FCG:

- Lack of knowledge about how to apply for the grant
- Lack of assistance for preparing application
- Length of time it takes to process applications
- Caregiver receives CSG and can not afford to be without a grant during the long gap for processing new application
- Caregiver applied for CSG instead because of short waiting period compared to very long period for the FCG

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[17] In instances where children over 18 years old can be shown to be attending school, the Child Care Act, s. 33 enables an extension to the placement and accompanying grant up until they are a maximum of 21 years.

- Distance to welfare office and associated transportation and opportunity costs
- Problems with bureaucracy or welfare personnel
- Corruption in the system
- Lack of role models who have received the FCG
- Biological parent is still alive
- Stigma/social obligation

Although a common explanation we received about why few people apply for the grant was related to information: "it's the lack of information…people don't know about the grant" (Zondi), among our case study households, only said she had not heard of the grant at all. All others had heard of it, and had a general idea of what it was and the requirements to receive it. A surprising number of people were able to talk about the grant—the documents needed (i.d. document, child's birth certificate, parents' death certificates) compared to the number of households who had actually chosen to go through these procedures. Explanations sometimes appear to confuse the requirements of obtaining the FCG and CSG, however. Knowledge is based on word of mouth and is fairly vague.

More widespread was a reported lack of knowledge about the process of how to apply for the grant, and lack of assistance in obtaining it. A lack of contact with welfare offices or social workers to inform them of the grants was one reported problem, but since a large number of households in the study communities were receiving the CSG, it appears that more outreach has been conducted with respect to the CSG.

KIDS 3 community survey data from 67 clusters reveal a fairly low level of support for households when it comes to foster care. Table 5.2 indicates whether employees from particular sectors—government, private sector, NGOs and CBOs/FBOs—had been present in the community in previous year to help people in different ways. With respect to help in the area of foster care, in urban areas,[18] the main source of support is NGOs at 59 percent, compared to NGO support in rural areas of just 14 percent. Government offers the next largest source of help related to foster care in urban areas (48 percent); but is also far less present in rural areas (26 percent). Even CBOs and FBOs helping with foster care are far more present in urban areas (44 percent) than in rural ones (just 7 percent). The private sector appears to play hardly any role at all. The KIDS 3 data also found that elected representatives, tribal authorities and 'ordinary community members' provided close to no support related to foster care. Table 5.2 also confirms what was found in the qualitative data with respect to a greater presence of the CSG. When it comes to wider forms of welfare assistance, which included the CSG, the amount of support is much greater—approximately 70 percent government support in urban and rural areas. Here again urban areas are still better served by NGOs and FBOs than their rural counterparts.

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[18] Note that the rural/urban definitions used in KIDS 3 in 2004 were the same as those used in the 1993 survey; official definitions that have since changed.

Table 5.2: Forms of assistance provided in communities (percent of 67 KIDS 3 Survey communities)

Type of employee providing assistance in previous 12 months	Social development		Foster care		Government welfare program including CSG	
	Rural	Urban	Rural	Urban	Rural	Urban
Government employee	21.43	52.17	26.19	47.83	72.72	69.57
Private-sector employee/business person	0	26.09	0	4.35	0	13.04
NGO employee	4.65	47.83	13.95	59.09	2.27	34.78
CBO/FBO employee	4.65	43.48	6.98	43.48	0	21.74

The KIDS survey, however, did not ask about the use of informal social networks in conveying information about grants—an important finding in the qualitative study. These social networks were also important in showing that obtaining the grant is possible—by example—cases of households that actually receive this money. In the case of the CSG, information and examples circulate through these networks. In the case of the FCG, it has not (see Box 14).

Box 14 Social Networks and Belief in the FCG

No one has encouraged or no one has proven that it's possible to get this grant…the grant is not well known in the community…The community members were talking about this foster care grant but they did not have all the details on how to apply…They didn't know the requirements. They need someone who can give them that kind of information or details to do the application procedure…They don't know whether it's difficult or not to apply for the FCG. They've never met someone or know anyone who has had this experience to given them an idea of how its like to apply for it…The Foster Care Grant is like a rumour that's going around the community, since they don't know anyone who is actually receiving this grant. They can't point at one person. (Msimango)

In fact, information received through social networks was most often discouraging—as conveyed by one respondent who said that she *"had met a number of people who had said this grant was almost non-existent, according to the information supplied by the local welfare office."* She said she had *"never met anyone who had applied and received it."* (Mnguni).

Many stories were recounted by those who had applied and, more often, about others whom they knew who had applied, revolved around different types of problems experienced in efforts to apply. There were concerns about the time and energy required, with highly uncertain payoffs (see Box 15). One problem is distances to the welfare office and the cost involved in getting there. A number of respondents said that they would apply except that they can not afford to travel: *"Mpiyakhe says he is planning to visit the Welfare Office sometime, when he gets enough money to find out about all the procedures and requirements to apply for this grant." (Msimango)* The perceived unlikelihood of a successful application makes the cost higher than the perceived benefit. This is compounded where visits to the welfare office must be repeated, and of course telephone communication is not available to follow up: *"She was told to come next month. She had to go there because she does not have any phone where they would have contacted her. (Mbatha)* Various frustrations are encountered at the welfare offices:

> *Themba said she had heard that the money was difficult and the people who had applied were having serious problems in trying to access it. They are told different stories by the welfare office…: the money had not been released by the government and they had a year to apply for it and she had not met someone who had got it. She felt that the councillor for the area was not being proactive (Ngidi)*

Box 15 The Opportunity Costs of Applying for the FCG

Patricia is not a registered foster parent…It is a problem for her because the Welfare offices are far away from the community. She will have to spend transport money to get to the Welfare offices. She is worried that it might be a waste of money to get there just in case they do not approve her application forms. She believes that people do not get their grant when they apply for them, like [they do] the disability grant and the CSG. They have to redo the application procedures. She says that she is too old to be up and down going to the welfare offices. She does not have the energy to travel as the grandparent. She says that it is a long process to finalize the grant…She has observed many people who are struggling to get their own grants. She has never thought about applying for the foster care grant. (Khubona)

Another issue that arose repeatedly in the interviews related to the amount of time it takes to process the grant—the long waiting period. An important dimension of this is the implications for the CSG—although they are aware that the FCG is much larger, many people expressed concern about losing the CSG, and not being able to afford a period—even a few months—without either grant. For this reason, people choose to stay with the CSG:

> *People were talking about the delays and because of the time delay in the process and waiting to go to court to them is a big delay because they are hungry…So people just go for the child support grant because one has to wait for three months and then get it. For foster care one can wait up to three years for it to be approved. (Mbatha)*

One of the few households in our study with the FCG said that they waited eight months for the FCG certificate and *"there are times when you don't even get this certificate…The process of application for the grant takes a very long time and some people give up and stop doing the process*" (Mchunu) Others hear these stories and have *"lost interest"* (Bongani) in applying.

Other stories and concerns revolve around difficulties in obtaining the necessary documents (birth and death certificates). An important factor is the applicant's relationship with the parents of the deceased—often the parents of the child's father—determining the ability to obtain the father's death certificate: *"She was doubtful to apply for this grant because she does not have the death certificates of the fathers of these children since she does not have a relationship with their families…she has the certificates of the mothers of orphan children" (Zondi)*. Another explanation reveals a different type of problem, inter-household conflict over access to resources:

> *Some people do not have the necessary documents, e.g., own identity document, death certificate. In some case one finds that the child was living with the father's family and he dies. This family wants to apply for foster care grant and the other family does not want to give them the death certificate for their daughter because they also want the child so that they can also apply for the same grant.*

In even more difficult circumstances are the fostering adults who do not know whether a biological parent is alive. Welfare officials advise applicants to look for the father, who may not be possible to locate, or proof of his death may not be easy to obtain. One women taking care of an orphan said that it is *"not easy when the officials ask you to go and look for the father of the child and yet she does not know the father. When the mother of the child died she did not get any support from the father because she did not know where he was."* (Mkhize). In other cases, a biological parent is alive and the fostering parent is thus not eligible, yet all contact with the biological parent has stopped and it would be impossible to locate him or her. In this case the children are living under conditions no different from those of orphans, but are not eligible for the grant.

Other concerns revolved around the perception that social workers at the welfare office were rude, did not have the time, or were not concerned about people's needs. What emerges from people's accounts, although the respondents do not always perceive it this way, is a shortage of social workers and other welfare office workers to process the cases. This is consistent with the claims made by Meintjes et.al. (2003): that the use of the FCG as a response to the HIV/AIDS crises will overburden an already overburdened child protection system. The picture that emerges from our research is also that of a system that is not coping with applications.[19] People applying for the grant take it personally however:

> *Her problem is with Welfare officials. They are very rude and they don't care about the needs of the people…The Welfare officials don't even give you a chance to explain your problem or listen to people…The Welfare officials said they are tired of the people who don't have information about the fathers of the children…it is very irritating to beg the Welfare officials (Bongani).*

Only one case raised the issue of corruption, in this case a claim of collusion between the Welfare Department and crime syndicates.

Finally, stigma associated with the FCG is raised by one household, and although appearing to be uncommon it is nonetheless an important finding—an issue not previously revealed in other studies on orphans in South Africa: The Mbongeni household does not wish to receive the FCG *"as it meant that they were failing to support their late brothers' son or the neighbours might even think that the household is ignoring [the orphaned child]" (Mbongeni).* The family is also concerned about the implication that they are benefiting from the death of the orphans father: *"Registering might carry the connotation of [getting] an income at the expense of [the orphan]. It is like enjoying the death of their late son so that they could exploit the benefits accruing from his death (Mbongeni).*

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[19] Presumably this is a question of quantity and quality of staff and other resources dedicated to the process, i.e. with greater investment of resources the system could cope better. Still, as we will revisit in the conclusion, Meintjes et al. (2003) make the point that the FCG is part of the child protection system and necessarily involves a system too complex and expensive for processing the massive number of orphans cases that have emerged and will continue to as a result of AIDS.

5.3 Other forms of Support for OVCs: Formal and Informal

As discussed above, the main government interventions supporting the livelihood of OVC are the Child Support Grant (CSG), which is intended as a poverty alleviation measure for all poor households, and the Foster Care Grant (FCG) targeted at orphans. It is likely, however, that investing in strengthening the social fabric of families and communities, rather than providing only one-way channels of support, will result in improvements in the children's wellbeing. An examination of existing formal and informal interventions in varied geographical settings (urban and rural) can shed light on practices that could be scaled up and needed forms of support. Subbarao and Coury (2004) stress that there is no 'blue print' or 'ready to use package' to channel assistance to OVC. Children's vulnerability is context-specific and any intervention needs to be well-understood, and carefully tailored to the socio-cultural environment where they are introduced and evolve.

To gain an overview of types of interventions that exist to support orphans in the province, semi-structured key informant data from telephone interviews from the wider KIDS sample (see section 2) were categorized into formal and informal interventions implemented by government, NGOs, CBOs and FBOs. Informal interventions involve social networks mobilizing internal and external resources for care. These include assistance from immediate family, extended family, friends, neighbors, CBOs, FBOs, and churches. Formal interventions are carried out by the State and NGOs. These include state social assistance grants, social services, care services, and livelihoods projects. What emerges from these interviews is a picture of very limited forms of support, outside of the state cash grants, a finding supported by the further qualitative interviews carried out in the six study clusters. The KIDS 3 data supports this picture as well. Returning to Table 5.2, forms of assistance in the area of social development—which could include types that could benefit orphans and their fostering families—is low in rural areas. Urban areas reported more social development activity, though many urban areas appear to have had not contact of this kind as well.

Fostering households in this study have a wide range of needs (see Box 16). The most universal of these is financial—poverty is endemic across the study households and it is difficult for many foster households to make ends meet. While household interview informants are keen to emphasize that orphans are treated the same as other children of the household, and that no one is eating less as a result of the presence of adoptive children in the home, the fact is that all of these households are in a highly precarious economic position. Virtually all household interview respondents cited difficulties in finding money to pay for essential needs such as food, school and clothing. Many grandparent foster parents relied completely on their limited pensions to manage these expenses: *"Patricia has the problems of paying for his school fees. She says that she pays R30 for the school fees. She has to buy the school uniforms and it's difficult for her. Sbu has only one school trouser and it's a problem if it's raining. He does not have another trouser to wear in school. She is using her pension to buy food for her children. They are not a big family. But there are times when she can't afford to feed them"* (Khubona). And while there are various support options found across the communities, not all of these are present in every community, nor do they reach every household or child with need. Many households in this study do not have access to any services or assistance programs (see Box 17): "*Thandi and Mpiyakhe insist that they have not received any kind of assistance as the result of orphans in the household. The orphaned children have been supported in the household like all the other family* *members. Mpiyakhe says that they've never experienced or gotten any support or assistance to show that there are orphans in the household. He says that household members have been struggling to survive or to make a living and to have that plate of food everyday. He says that there are good days and the bad days in the household"* (Msimango).

Box 16 Interventions Needed

There are so many things that need to be done in this community. They need community based organizations to help the orphans. They need community organizations where orphans and poor children should go for all the assistance that they need in their daily lives.... They need development projects to help the families of orphans to make a living and to support their children. (KII, teacher Mrs. H)

...orphans should be given training in life skills so that they can provide for themselves or better still, give them food vouchers in case they have reached the age of eighteen years. The social workers should become more pro-active and visit the child-headed households so as to assess the economic and social situation. (KII Mrs. B)

They need education and be able to access everything like, getting the good education, the shelter, foster parents, health services if they need it, emotional support and they need outings as orphans...They need other organizations like gender organizations, rights of children organizations, youth programs in the community. They want to train youth for other projects. There are more births in youth. There is a high rate of pregnancy, the youth drink too much alcohol, and young people are dying of AIDS. They need programs to educate young people and also involve them in community projects to protect them away from sexual activities. The communities need education on legal adoption of children. They have to educate the people to register children because if unregistered they can't access other things, they can't claim for children and get assistance like the Foster Care Grant. (KII Manager at Drop-in Centre)

They need more support, they need funds, counseling and there is a need to do the follow ups on children if they are doing okay. They need to run workshops with foster parents to give them support and train then on parenting skills. (KII Social Worker)

Box 17 Nowhere to Turn

Kotozile said she did not receive any assistance from anyone, members of the community, councilor or the garden committee people. She said there were some times when she needed help, food parcels the community health worker said she was going to organize for her but never come back with them. When she saw on the street she said the councilor said she must come to collect it herself. She said she went to see if she could get them but she was told that as soon as they got them they will be sent to her of which that never happened. She went to social workers office for the same food parcels because thing were getting hard for her, the money she had at the bank was getting dry so she needed food. When she got there she was told that food is finished they had no idea when were they going to have it. (Mbatha)

Where households that have no access to either government, NGO, CBO or FBO interventions, this can be because such programs do not exist in their communities, or because of a lack of knowledge, or also because while State grants are targeted at orphans and foster households, other interventions must spread their services around. Households with no access rely upon other means of support. Where social capital is strong and networks have some resources to share, neighbors and friends provide help with food and clothing. Household informant interviews are peppered with references to small but important gestures of kindness, generosity or flexibility held out to orphans' foster households: *"The teachers and the neighbors simply decided on their own to donate food, not being approached by any of the [fostering] household members. They had heard through other children that the household and the children were having serious problems... the food donations and money from the various people were a measure of great relief"* (Khondlo). In this same interview, we find that the school principal waived the school fees owed by the household for the year 2003. Even the *mashonisas*, or community money-lenders, occasionally agree to forego or reduce interest charged on loans to foster families. As explained by two case study households:

> *Nandi said Mpo and herself approached the* mashonisa*. She did the same thing after the death of Mpo. The* mashonisa *are the people who lend money to the community members and the loans are charged interest on a weekly or monthly basis. The going rate is 16 percent, but in her situation the* mashonisa *would either reduce the interest to 10 percent or simply not charge it at all. Nandi said the* mashonisa *are a welcome presence in the community because they are able to assist in time of emergencies, although sometimes they rip off the borrowers by attaching their assets until such time that the money is settled in full. She did benefit from the loans in that they enabled her to settle some of the things that she was worried about in terms of the domestic budget"* (Khondlo).
>
> *the money-lenders are local people who have known her for many years. Others are just ordinary people who assist out of sympathy and do not require that the money be paid back. For this kind of assistance, it is not big amounts, ranging between R50-R100. These monies are not necessarily meant for the orphan, but for the general household. Themba also buys food on credit from the local shop and she pays monthly"* (Ngidi).

The same informant pointed out that local moneylenders acted as an informal channel to support foster households in need, because of their proximity to the communities and the willingness to lower or eliminate re-payment interest for orphan's foster households.

In some cases where borrowers were completely unable to repay *mashonisa* loans, they discharged their debts by tilling the fields of the *mashonisas* or offering other labor. Obviously, borrowing under such desperate circumstances also carries with it the danger of becoming caught in an endless cycle of debt and repayment; one household described a situation in which their employer would offer a salary advance each month, then require that it be paid back in its entirety on the next payday, with the result that the borrower would be forced to take another loan or advance to get through the month.

A small number of luckier foster households—those in which a deceased parent held formal sector employment—benefit from provident fund payouts that can be applied to orphan and household support.

Although the overall picture is one of limited and ad-hoc forms of support, an examination of non-formal support for orphans and fostering households established that there are a variety of channels through which these children and households receive help. The analysis of rich data from key informants showed that NGOs, CBOS, FBOs, and community and household members are well aware of the children's needs and their support is offered through overlapping streams of material goods, money, food or other more abstract help such as care, and time invested assisting the child or the foster household. The assistance takes many forms: loans, food donations, clothing and school uniforms, fees for school, or school fee waivers, and help with health and psychological counseling. Another kind of support is the availability of drop-in-centers and community centers offering a variety of services to orphans. These are mostly run by CBOs and provide children with some food, activities, and sometimes a place to stay. However, these were only available in a few communities.

Other non-cash forms of support were accessible through CBOs, the institutions with the most visible presence in the communities studied. CBOs usually made services available to the community as a whole, though some directed assistance at orphans. In one community, a social worker interviewed described a CBO-run home-based care program that was *"contributing immensely to the intellectual capacity of the children as they were also helping them with their homework. They also did laundry work. Most of these activities were being undertaken at the multi-purpose centre located in the area. In addition, the care givers were offering the counseling service to the children. The welfare office was planning the construction of more of these multi-purpose centres. They were due to be built in Wembezi, Ladysmith and Bergville"* (Osizweni).

Households supplement their needs through a combination of formal and non-formal interventions. For example, communities received livelihood support from the provincial Department of Agriculture (DOA), in the form of seeds, fertilizer, fences, equipment and other tools. Communities and individuals also organized themselves, initiating income generation activities such as community gardens that were supervised in most cases by volunteers and community health workers. In one community, the vegetables harvested from the gardens were sold or distributed among community members, including those households with orphans and ill people. This is an example of coordination between formal and informal interventions—a program offered by the government is subsequently enhanced and targeted through the work a CBO.

Interventions by NGOs fewer than those of CBOs; however, where they were present they were important: "t*here are no local NGOs, but there is one that is located in Newcastle (Heard) and has just started working in the area. They are involved in the area of HIV/AIDS. They are focusing on the orphans and monitor their social environment. Previously, the study focused on children whose parents had died of HIV/AIDS, but have shifted their focus to orphans whose parents died of other diseases as well."* Some NGOs are stretched thin, such as one described that was serving 40 wards, identifying orphans and referring them to social workers.

Faith Based Organizations (FBOs) also assisted orphans in several communities, filling a gap where no other support was available: *"apart from this Roman Catholic Church structure, there is also an Anglican Church-aligned home-based care. They also act as the referral service for the local clinic. They are taught how to monitor the health progress of the children. They are focusing on the HIV/AIDS activities whereby the patients are given food and educated on cleanliness issues. They visit their homes to cook food for them. They also do counseling"* (KI, clinic nurse, Osizweni). In another community an FBO ran a drop-in center for children. This was explained by Sister M, the person in charge of a program near KwaDunuse: "*this program is run by the FBO attached to the Roman Catholic Church and the orphans are accommodated at the Assisi shelter. They work closely with the social workers who monitor the socio-economic conditions of the children. Assisi accepts both the affected and infected children*." Shelters and drop in centers are not always run by institutions or government bodies; often, communities take care of their orphans by offering food and board in their own homes: *"there is a lady in KwaMashu who takes care of orphans, but it is too far away, and the orphans from this area don't go there"* (KI, clinic nurse, Ntuzuma*).* FBOs try to address children's most pressing needs: food and health care. Sisters H and N, also from the South Coast area, added: *"this is a home-care programme run by the Roman Catholic Church. It does not discriminate on the bases of denomination. It offers the services of volunteers. They visit the sick and even work in conjunction with social workers. They provide food for the orphans."* They added that social workers run parallel programs offering access to referrals and health advice, enhancing the Church efforts: "*there is a programme that is run by the social workers and they refer the orphans to the clinic for medical attention. The social workers deal with both the affected and the infected orphans. The social workers also rely heavily on the input of the onompilo because they are always in the field working with the different families and they have an understanding of the needs of the community members."*

In this study, additional key informant interviews were carried out with representatives from six organizations that provide various kinds of assistance to orphans and foster households. These were the Richmond Drop-In Centre (Ndaleni), Mrs. L's Drop-in Centre (KwaMashu), a vegetable growing program (Umlazi), an orphanage (Osizweni), a Welfare Office (KwaMashu) and an orphans development committee (KwaDunuse). In the following subsections, we present some specific information about these services.

Richmond Drop-In Centre, Ndaleni Cluster

This center offers a broad range of services for orphans and foster families. After-school feeding is provided at the center itself, but in addition to this, food parcels and vouchers are sometimes available for distribution to foster households. Orphans are given the opportunity to be involved in activities and trips away, and younger children can take advantage of the toys provided by the center. The center benefits from the services of trained volunteer social workers, who in turn provide counseling to foster parents to 'empower them with parenting skills'. A particularly important service provided by the social workers associated with the center is assistance in applying for government grants such as the Child Support Grant and the Foster Care Grant. The Richmond Drop-in Centre carries out a systematic targeting exercise in order to select beneficiaries: household questionnaires are applied and observations of poverty level, health status and orphans' general condition are carried out by volunteers and home-based care givers. Emphasis is placed upon selecting the poorest and most at-risk children; the principal also noted that at times people who would not be selected by these criteria do attempt to access the benefits of the center. Training is provided to center personnel in the form of capacity building courses on a range of topics such as child care and project management. These courses are financed by the government, which indeed finances the project as a whole through the Department of Social Welfare.

Mrs. L’s Drop-in Centre, KwaMashu

As noted earlier, KwaMashu was not one of our of our six study areas but rather an additional township outside of Durban. Mrs. L’s Drop-in Centre is a non-residential drop-in center. Like the Richmond Centre, it offers a range of different services for orphans and foster households. Young children can be brought to the center during the day while parents are at work: for this crèche-type service, Mrs. L levies a charge of R50.00 per month. School-aged children typically go home to change after school, then come to the center in the afternoon for help with their homework. The center also coordinates with teachers to help monitor children’s educational progress. Both after-school feeding and take-home food are provided by this center. The center also provides assistance with medication for minor illnesses and benefits from the volunteer efforts of a number of retired nurses, although so far no doctor has volunteered to provide pro bono services. Mrs. L accepts orphans of both sexes, but imposes an age limit of 14 years. She also will not accept a school-age orphan who is unwilling to attend school. Mrs. L receives no formal financing and funds her activities through donations solicited from friends and community members.

Vegetable Growing Program, Umlazi

According to the representative of this program and other key informants in the area, it is the only assistance available for orphans in the community (Umlazi cluster). Vegetables are cultivated in the township; once harvested, they are distributed among orphans and foster households. The informant noted that she had invited care givers to participate in the gardening work, but that this had not met with a good response. Selection of beneficiaries is simple: it is enough for people to approach the organization to receive help. The gardeners have received some skills training. They receive seeds from the government; when these run out, one of the counselors purchases seeds from their own pocket. The informant noted that the organization needed a properly titled plot of land for its activities, which were currently constrained by the fact that the land under cultivation lies within the boundaries of the school and cannot be accessed during the holidays when the gates are locked.

Orphanage, Osizweni

This orphanage was not in the Osizweni cluster in our study, but in another part of Osizweni some distance away. The principal interviewed emphasized that this was an orphanage, not a temporary shelter—a long-term care option rather than an emergency stopover. The orphanage has trained professional staff who follow particular protocols of care and screening in the case of each orphan. Orphans are offered counseling and group discussion therapy sessions. Orphans can remain at the orphanage until they are 18 years old, but the principal noted that the orphanage preferred to avoid this situation because it could create a dependency complex that would cause problems in the future. In addition to food, shelter and counseling, the orphanage offers a play area, school support and school uniforms. Personnel include social workers, child care workers and a volunteer doctor. Reflecting current thinking about care of orphans, the principal acknowledged that while providing crucial services, orphanage care was not a perfect substitute for family-based fostering. The principal also noted that no discrimination took place in the process of finding place for orphans. Race, sex, poverty level, age and educational level were not taken into account in determining access to the orphanage's services. Capacity building is provided to orphanage personnel in topics such as basic child care, counseling and first aid. The orphanage is financed in part by the government, in part through their own fundraising activities and in part by local and overseas donors, but there is a need for more financing.

Welfare Office, KwaMashu

The Welfare Office in KwaMashu is an NGO program with a long history in the area. It offers a limited but important range of services for orphans and foster households. Its principal activity is assisting potential beneficiaries with their applications for Foster Care Grants, although personnel do also offer some counseling where this is requested. Assistance with grant applications takes the form of informing foster parents of the kind of documents required, filling out forms, and at times accompanying them to court. No targeting per se takes place: the Welfare Office assists all those who come to seek help, although they do not themselves actively seek beneficiaries. NGO personnel have received skills training in counseling. This NGO receives a government subsidy as well as sporadic assistance from the Durban municipal authorities, but the informant interviewed noted that they are forced to look for additional funding.

Orphans Development Committee, KwaDunuse

This committee in KwaDunuse was elected by the local community, in response to a perception that the problem of AIDS orphans was getting rapidly worse. The committee is comprised of respected community members, such as teachers, a school principal, a village leader and a teacher. The committee liaises with an organization called Noah in Durban. One of the important activities of this committee is helping orphans to find or acquire their birth certificates, a vital first step in the process of applying for the Foster Care Grant.

6. Conclusions and Policy Implications

The stage of the pandemic in South Africa is such that the majority of HIV infected people (75 percent) are in stage 1 and 2 of disease progression. The implications are two-fold. First, the country is seven years away from experiencing the peak in the number of orphans. Second, large numbers of children currently live with, and often care for, ill adults and younger children (Giese et al. 2003). We are facing an immediate but highly neglected challenge of supporting large numbers of children currently living with and affected by the HIV/AIDS epidemic in many ways.

While much of the discourse surrounding this topic has centered on the dynamics of children once they are orphaned, the first part of this paper has emphasized the importance of the trajectory of HIV and the corresponding effects on children. In examining the epidemic from this approach, we are able to discuss the complex realities of children in affected households and the implications for policy. One of our first findings involved the living arrangements of children. As with children in non-affected households in South Africa, children are highly mobile and often live in multiple houses, across diverse areas of the country and with different caregivers throughout their childhoods. Our results emphasize this mobility in the era of the AIDS epidemic and the fluidity of child care throughout family networks. While the South African social welfare system has taken positive steps to increase both the amount and the ages by which a child can receive a Child Support Grant, the rigidity of the system is not able to address the fluidity of mobility of vulnerable children. It is important that Department of Social Development policy focuses on the realities of AIDS-affected children to ensure that those caring for children have access to as many resources a possible to successfully cope and care.

Considering that they are involved intimately with providing care to HIV-positive family members, there is an urgent need to strengthen the support children receive so that they are able to assume these responsibilities effectively and with minimal consequences to their own well-being. HIV/AIDS education received at school makes it easier for children to understand what their parents are undergoing, and decreases the burden on parents in having to explain to their children what is happening—something they may not fully understand themselves. Findings from our research reinforce the fact that life skills training at school can positively impact and work to better adjust children to the realities occurring in their homes.

Beyond education initiatives, there is a serious need for more comprehensive counseling programs for children both directly and indirectly affected by the AIDS epidemic. For those children living in affected families, there remains a need for external support and counseling. Chronic illness and death due to AIDS are very difficult to bear witness to, especially for children. Currently, in all three provinces in our study, Eastern Cape, Western Cape and KwaZulu-Natal, there are very few counseling services directed at children in order to provide support for their emotional state and well-being. Further, in order to alleviate stigma, children who are not directly affected should also be a part of such initiatives in order to better understand the realities of their peers. In doing so, children may be prepared to become mutual support networks. We have seen evidence from Mbekweni where peer support groups have been initiated by local NGOs and Community Health Projects that have worked to fill in part of this void, but it is only a start, and we found no evidence of such programs in other regions of the study. If we are to ensure the future well-being of children, we must do so before they are orphaned, and with a variety of community-based, human capital initiatives.

The question of disclosure to children and the experiences surrounding the event brought forth many important issues throughout our research. To date, there has been no research looking at the experiences of disclosure to children in any African setting. In order to effectively address the impact on children and what makes them vulnerable, we must begin by supporting women and families to disclose to their children so that they can better prepare themselves for their futures. Because an HIV-positive status carries with it stigma, shame, fear and denial, disclosure to any loved one is an extremely difficult decision to make. Disclosure to children is especially difficult and represents an extremely sensitive issue on the HIV/AIDS landscape. Mothers especially are often uncertain when or how to broach the subject, and counseling to support this issue is almost nonexistent. Our research has found that disclosure of a mother's HIV status to her children is a critical first step in family solidarity, preparation for impending parental illness and ultimately, death. Disclosure is also necessary for children to be effective agents of response, in that it places them in a position of knowledge and capacity in their families.

In order to begin this process, however, HIV-positive caregivers need information on how, when, and under what circumstances they should disclose to their children. An example of the miscommunication surrounding this issue is the question of what constitutes an appropriate age for disclosure. This subject has not been addressed in the literature, except that on disclosure in the West, but even this does not come to a conclusion about whether disclosure is ever preferable for children. However, women in South Africa are asking these questions, and there is no one to give them answers. Part of the problem is that every family and child is unique and no universal age will be appropriate for every individual grappling with the decision. This is why parents need to be counseled on an individual basis as to whether or not they are ready to disclose to their children, as well as on possible strategies to mitigate the potential for distress. In terms of disclosure to children then, one clear policy implication is the need for expanding and intensifying counseling services so that mothers and children are better prepared for the future. Once parents disclose their status, children need access to support to accept this new reality and proactively and constructively engage as agents of response. Our key informant interviews show a void in counseling children to effectively deal with complexities of currently living with an HIV positive adult and preparing for even mortality of their parents/PCGs. There is a large and immediate need to expand services to reach children.

Our research also examined the processes by which women plan for the future of their children. For mothers who are aware of their HIV positive status, making plans for their children represented a chance to take part in their children's future growth and development. In the majority of cases women had indeed thought about the future of their children and in many cases, discussing the support that their future caregivers would bestow upon their children made the issue that much easier to face. For the women in our sample, making future plans created a peace of mind by assuring them that their children would be cared for according to their own wishes, and by those they felt would love and care for them in their absence.

Considering the importance of planning for parents, potential caregivers, and the children involved, it is important to highlight some of the barriers that mothers indicated in carrying out planning. The most important barrier to planning was that of financial capacity. For the most impoverished households in South Africa, the ability to save from meager wages, remittances, or the income granted through government support is rarely possible. In HIV/AIDS-affected families, these realities are exacerbated as parents must also contend with the costs associated with chronic illness and inability to work due to illness. While many of the women in our study emphasized the desire to save for things like the future educational requirements of their children, meager earnings made this rarely possible. Our research demonstrates two important findings. The first is that women are in fact planning for the future well-being of their children, and in doing so are actively involved in mitigating the future impact of their own AIDS death. The second is that the main barriers to further planning have the potential to be addressed through creative programming and policies that acknowledge this reality.

What needs to happen from a policy perspective is a bolstering of what women are already doing as well as an engagement with the barriers they have identified to their own initiatives. Programs need to address the ways women can save or invest in their children's future under the constraints of poverty. Women need legal assistance in accessing child support from fathers of children and in planning for inheritance. They also need assistance in ensuring that their children can access grants even after their eventual death and consequent migration of children. Women need to feel that they are able to take part in the future financial security of their children, and children need to feel that their parents, while no longer alive, have left them a legacy. Policies and programs need to reflect this reality and find creative ways for women to do this. In Africa, succession planning, in which children and their parents are supported before the death of the parent, is increasingly being adopted by NGOs. Such interventions include helping parents to write wills and appoint guardians, creating family "memory books," and other activities that promote the long-term wellbeing of children (Clarke 2005; Horizons, Makerere University Department of Sociology, Plan/Uganda. 2004). Although more rigorous evaluations are needed, a recent review and analysis of psychosocial programs for children affected by armed conflict and children affected by AIDS found these programs to be highly beneficial to children (UNICEF expert consultation 2005). Such activities need to be intensified and scaled-up.

Our research findings highlighted the fact that for the majority of households interviewed, extended family networks still had the capacity to absorb orphaned children into their own homes. This has important policy implications in that as long as potential caregivers are able to garner support through government grants, as well as are able to access counseling services, the extended family safety net seems, for the time being, capable of catching many of the children affected by HIV/AIDS. While this reality will certainly become more difficult under increased pressure due to higher numbers of AIDS deaths, bolstering initiatives now may mitigate this impact.

To a large extent, our research supports conclusions of other authors who have argued that household mobility patterns over many decades have left children living without biological parents, so that the 'adoption' of 'social orphans' is a long-established practice in the South Africa. Processes of adoption and caring for children orphaned by AIDS are thus articulated with this pattern. As noted above, we find that across the three provinces, existing family structures are mostly coping with the care of orphans. The primary obstacles to the provision of adequate care of orphans are not sociological but economic. There is clear evidence that the care of orphans should largely be left up to extended families where families are willing and able to take them in. However, they need a wide range of material and non-material support systems to help them cope economically and socially.

Imagined notions of 'African culture' have also articulated with current practices, and our informants offered a range of beliefs about family obligations toward orphans. While some informants stressed the social ideal of patrilateral relatives taking responsibility for orphans, the reality seemed to mainly be that of responsibility taken by matrilateral relations, i.e., aunts and grandmothers. Our case studies reveal several reasons for a divergence from an idealized protocol of patrilateral responsibility: one is that terminally ill mothers are often cared for by their families, and their children remain in the same household after their death. A second reason is that many children do not maintain links with their fathers and/or fathers' relatives; fathers have often long disappeared. Another, less prevalent, reason is that despite formal obligations of father's relatives, brothers' wives are not always welcoming of the children. Few conflicts were found around decisions to take in children, although those that occurred are important to note. These primarily related to the tension between the patrilocal residence ideal and the matrilocal status quo. Another basis for conflict that arose was where care of the child is associated with material benefits: obtaining the deceased's property or access to social grants.

Our research also confirmed what is widely recognized in the South African literature on social and biological orphans as well as that on child poverty—that the main caretakers for children are grandparents, and primarily grandmothers. The Old Age Pension is then a crucial social safety net for orphans. However, unlike a family structure arrangement where the OAP contributes to households that have other sources of income from a child's parents, the addition of orphans adds a financial strain onto households with little other forms of financial support.

Households studied here articulate and negotiate two overlapping but not necessarily congruent models of 'adoption'. The first of these is an official legal procedure of 'fostering;' the second is a customary practice, seen as 'natural.' Assuming the duties of caregiver is expressed as a cultural imperative. Despite the enjoinment of adoption by social norms, foster parents offered several reasons for legalizing the fostering arrangement. The main motivation is access to state grants, primarily the Foster Care Grant (FCG). Another motivation is where legal adoption protects matrilateral caretakers from custody claims by patrilateral relatives. On the other hand, most households do not formalize the fostering relationship, primarily because of insufficient information about or ability to undertake the application process, coupled with a strong belief in customary adoption—a customary fostering household will sometimes not proceed to legally ratify the relationship because they believe that the child is already 'sufficiently' adopted.

An issue that preoccupies much of the literature on orphans in Africa is that of conditions of orphans in their new households, particularly in comparison to non-orphaned children. Stigma is a related issue important in discussions on impacts of HIV/AIDS and to a lesser extent, orphans. Discrimination and stigma are relevant both in emotional/psychosocial terms and in terms of physical care and nurturing of children. We found discrimination to be a difficult topic to research, eliciting pride and defensiveness among informants. Household interview responses strongly emphasized the equal care and love they give to all children of the household, and our researchers' observations of these households at least in short visits over a period of time, convinced them that discrimination is not a widespread or obvious problem in these households. However, the existence of two household accounts of serious discrimination and key informant's accounts that refer to wider groups of households, suggest that discrimination against orphans at the intra-household and community level does exist.

Problems at school were described to be more related to poverty—the material conditions of orphans—than to being an orphan per se, although the two are not unrelated. Most foster parents in our study seemed to be striving to keep their children—biological and fostered—in school, though situations were described in which orphaned children were too tired, hungry or emotionally disturbed to perform as well as they could have. However, in contrast to findings by other researchers of lower education indicators in Africa and South Africa, neither our qualitative research nor the KIDS 3 survey revealed significant evidence of disadvantage among orphans. Although a small sample of fostered children in the KIDS sample may be one reason why differences are not detected; it may also be because South African orphans are mainly living with close kin, a condition in which other authors have also found less differentiation. More extensive ethnographic research, a larger survey sample size and/or regression techniques would be needed to develop a better understanding of the role and treatment of orphans in their new households and at school. Such an understanding could focus policy attention on, for example, options for education assistance for orphans. However, it is not necessary to do more research to conclude that orphans and fostering households are in need of the many forms of assistance we have identified here.

Our sub-sample of KIDS 3 households in our six study clusters did not include child-headed households,though key informants did speak of them. Qualitatively, if not quantitatively, this is a severe social problem insofar as it involves the most exposed and at-risk subset of an already vulnerable group. Such children face a gamut of risks and social problems, many of which are related to the coping strategies to which they turn in order to obtain food and money. Coping strategies reported include begging, casual paid employment, crime, sexwork, strategic pregnancy and early marriage. Child-headed households face particular problems and risks with respect to food and nutrition, schooling, health, violence, crime, discipline, teen pregnancy, and HIV/AIDS. There is a lack of specialized services to assist them. Dedicated community care workers as well as other adults in the community are urgently needed to monitor these children.

As emphasized throughout this paper, OVCs and ill and fostering households all urgently need a new focus from government. In questioning our study households about assistance from government or NGOs for the support of orphans and fostering households, we found little presence of support, and most of this was informal. Despite our conceiving a wide range of possible formal and informal interventions that might be available, we got little response at the household level. The main exception to this is two cash grants—the Child Support Grant (CSG) and the Foster Care Grant (FCG).

The KIDS 3 survey data show that about the same number of households applied for the CSG across fostering and non-fostering households, and about the same number are receiving it (about 30 percent receiving in both cases). However, fostering households have a much higher likelihood of being refused the CSG because the applicant was not able to be established as the primary care giver. The main reason for not applying for the CSG for fostering households is lack of the required documentation. Our qualitative research found the CSG to be the most important—and usually the only—source of support for orphans that the fostering household receives. These funds tend to be pooled within household resources, though the child also benefits.

Despite the fact that the FCG is largely the centerpiece of government policy on support for orphans, out of 207 foster households in the KIDS 3 study, only 1.9 percent reported receiving the FCG. Our case studies most households have heard of the FCG, and understand the basic principles and requirements. Sources of information about the FCG came from community health workers, social workers and others from the social welfare office, social networks, and the radio. The research also found many reasons for low uptake of the FCG. The main reasons revolved around the application process: dealing with the bureaucracy, a high level of scepticism among fostering parents as to whether they would actually get it; fear of losing the more secure CSG in the process; lack of knowledge of how to apply for the grant and assistance in applying; concerns over length of time to obtain it, distances to welfare offices and anticipation of unpleasant experiences related to rude officials, lack of necessary documents, and corruption. An influential backdrop to these perceptions is that fostering parents knew so few others who have actually received it--among their social networks they hear only stories of difficulties in attempting to access the FCG. Other less predominant factors related to their eligibility, mainly because a biological parent is still alive; or because of stigma.

Our research found that while South Africa has a more advanced system of social grants than other countries in sub-Saharan Africa, it is relatively underdeveloped with respect to other support programs supported by government, and local and international NGOs. In KwaZulu-Natal, most forms of support found were informal, such as neighborhood and extended family assistance. Apart from government grants, data from 21 clusters found mostly informal support from CBOs. NGOs and FBOs provided support structures but to a lesser degree. KIDS 3 survey data also found relatively low levels of assistance in the area of social development, particularly in rural areas.

Needs identified by households with orphans were mostly financial (though our observations and conclusions point to the need for counseling and other non-material support). All households cited difficulties in finding money to pay for essential needs such as food, healthcare, school and clothing. Some households have no access to any support from government or non-government sources. Neighbors and friends more often help with food and clothing, though social networks are made up of other poor people with little to share. A small number of more fortunate households, where a deceased parent had held formal-sector employment, benefit from provident fund payouts which can be used for orphan and household support.

In terms of the entire spectrum of support in pockets of KwaZulu-Natal, we identified CBOs, NGOs, FBOs, and households providing various streams of material goods such as cash or food donations, loans and reduced interest, clothing, school uniforms, fees for school or school fee waivers, and non-material supports such as care and psychological counseling. Another form of support is drop-in-centers and community centers offering a variety of services to orphans. These might involve a crèche, toys and field trips, school performance monitoring; after-school feeding and take-home food, and care for minor health problems. In some cases, these are CBO run and provide children with some food and a place to stay. The Richmond Drop-In Centre at Ndaleni provides a good model, providing after school feeding, food parcels and vouchers, field trips, toys, counseling, parenting skills, and assistance with grant applications. CBOs frequently provided a wide range of community services. Most are not directed specifically at orphans but at the community as a whole; however, where they exist they were serving as an important resource for orphans and fostering households.

Of the six case study clusters, four had some kind of NGO or CBO project that supported orphans; however, only two of these received government funding, and one of these was only for staff training. Other programs had to raise funds from community members—not a very lucrative source of funds. Some people take care of orphans by offering food and board in their own homes. Government programs were largely absent, though a noticeable exception was livelihood support from the provincial Department of Agriculture (DOA) in the form of seeds, fertilizer, fences, equipment, tools, and training in farming techniques (this program is not specifically for fostering households, but helps them). Communities and household members also organized themselves, initiating income generation activities such as a community garden supervised by volunteers and community health workers. The vegetables harvested from the garden were sold or distributed among the community members, including those households with orphans. This is an example of coordination that might be scaled up: formal state support offered by the DOA and subsequently enhanced through the work of CBOs.

NGOs have less of a presence in our study communities than CBOs. NGO members are said to be stretched very thin as they cover numerous communities providing support such as referrals or medical advice. FBOs seem to fill the gap when other organizations or government are not there, providing health monitoring of children, food, and health education, counseling, and assistance with grant applications. Social workers run parallel programs offering access to referrals and health advice, enhancing the FBO efforts.

With respect to responses to current conditions and preparedness for the oncoming surge in the number of orphans, government policy is significantly behind where it needs to be. The Child Support Grant is an important intervention that provides needed income support in a reasonably accessible manner, and uptake of this grant is increasing. Increasing the upper age-limit would better enable this grant to assist foster households with orphans, many of whom are older than 14 years. The Foster Care Grant raises more difficult issues. On the one hand it is at the center of government policy on orphans, and among the most impressive safety nets for orphans to be found on the continent. Its administrative structure is in place, it is becoming increasingly well-known and popular expectations around it are growing. However, our research found that uptake is thus far minuscule, that people have a wide range of disincentives not to apply, and that the social welfare system as currently structured appears not to be coping well at even the current level of applicants. If the FCG is indeed to be an important policy instrument then serious efforts need to be made to facilitate uptake and to respond to demand. At the same time, strong arguments have been made that the FCG is too expensive, difficult to access, places too much burden on the social welfare system personnel, undermines the grant's original child protection function; and unfairly targets a sub-group of poor children when assistance is needed by all poor children (Meitjes 2004). There is thus an urgent need for government to carefully examine its policy with respect to the orphans crisis, look realistically with options, and face what will be needed to respond effectively.

Aside from the question of grants, a wide range of interventions can support orphans and vulnerable children in other ways, and government policy is underdeveloped in this respect. Our research found a number of creative interventions providing valuable support to orphans, in the form of material goods, education and health monitoring, and counseling for children and adults—all critical parts of a comprehensive approach to OVC policy. But these are largely individual, uncoordinated projects run by CBOs or even individuals, largely without support from government, or reliable funding. Even where government support is obtained, it is on a project basis and not part of a coordinated program that could be scaled up. Some of the interventions we found involve interesting government-NGO partnerships that could serve as models for a scaled-up set of interventions. The private sector is another potential partner that has been tapped in OVC interventions in other parts of sub-Saharan Africa, which should be explored in South Africa. In developing these interventions, it is necessary to find a design that targets orphans but also supports other vulnerable children, so that policy is non- stigmatizing and fair to other poor children. The question of the relative material, social and emotional deprivation of orphans, soon to be orphans and otherwise vulnerable and poor children—and how to address this through policy—remains an open and critical one.

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